

Calendar No. 427

103D CONGRESS
2D SESSION

S. 2096

AN ACT

To improve private health insurance, to provide equitable tax treatment of health insurance, to reform Federal health care programs, to provide health care cost reduction measures, and for other purposes.

May 16, 1994

Read the second time and placed on the calendar

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IN THE SENATE OF THE UNITED STATES

MAY 10 (legislative day, MAY 2), 1994

Mr. DOMENICI introduced the following bill; which was read the first time

MAY 16, 1994

Read the second time and placed on the calendar

A BILL

To improve private health insurance, to provide equitable tax treatment of health insurance, to reform Federal health care programs, to provide health care cost reduction measures, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS; DEFINI-**
4 **TIONS.**

5 (a) SHORT TITLE.—This Act may be cited as the
6 “Health Care Reform Act of 1994”.

1 (b) TABLE OF CONTENTS.—The table of contents of
2 this Act is as follows:

Sec. 1. Short title; table of contents; definitions.

TITLE I—IMPROVING PRIVATE HEALTH INSURANCE

Subtitle A—Federal and State Roles

- Sec. 101. Federal reform and State implementation.
- Sec. 102. Applicable regulatory authority for health plans.
- Sec. 103. State health reform program requirements.

Subtitle B—Health Plan Requirements

- Sec. 111. Certified health plan requirements.
- Sec. 112. Additional requirements for accountable health plans.
- Sec. 113. Standard benefits.

Subtitle C—Improved Health Plan Delivery

- Sec. 121. Small group purchasing pools.
- Sec. 122. Employer responsibility.

TITLE II—TAX AND ENFORCEMENT PROVISIONS

Sec. 200. Amendment of 1986 Code.

Subtitle A—General Tax Provisions

- Sec. 201. Certain employer health plan contributions included in income.
- Sec. 202. Deductions for costs of health plans.

TITLE III—FINANCING AND REFORMING FEDERAL PROGRAMS

Subtitle A—Medicare

- Sec. 301. Medicare choice.
- Sec. 302. Other medicare provisions.
- Sec. 303. Income-tested medicare premiums.
- Sec. 304. Medicare administrative simplification.

Subtitle B—Health Discount and Medicaid Reform

PART I—HEALTH DISCOUNT

- Sec. 311. State health discount programs.
- Sec. 312. Health discount program design.
- Sec. 313. Financing health discounts.

PART II—TERMINATION OF AUTHORITY TO FURNISH ACUTE CARE SERVICES
UNDER THE MEDICAID PROGRAM

- Sec. 321. Termination of authority to furnish acute care services under the
medicaid program.

Subtitle C—Increase in Tax on Tobacco Products

Sec. 330. Amendment of 1986 Code.

- Sec. 331. Increase in excise taxes on tobacco products.
- Sec. 332. Modifications of certain tobacco tax provisions.
- Sec. 333. Imposition of excise tax on manufacture or importation of roll-your-own tobacco.

TITLE IV—IMPROVING ACCESS IN RURAL AREAS

- Sec. 401. Community health centers.
- Sec. 402. National health service corps.
- Sec. 403. Tax incentives for practice in frontier, rural, and urban underserved areas.
- Sec. 404. Incentives for primary care residents.

TITLE V—OTHER HEALTH CARE COST REDUCTION MEASURES

Subtitle A—Medical Liability Reform

- Sec. 501. Federal standards for State-based medical liability reform.
- Sec. 502. Certification.
- Sec. 503. Relation to other laws.

Subtitle B—Antitrust Provisions

- Sec. 511. Publication of guidelines for accountable health plans.
- Sec. 512. Issuance of health care certificates of public advantage.

Subtitle C—Administrative Cost Savings

- Sec. 521. Establishment of standards.
- Sec. 522. Enforcement.

1 (c) DEFINITIONS.—For purposes of this Act:

2 (1) AHP.—The term “AHP” means an ac-
3 countable health plan.

4 (2) ELIGIBLE EMPLOYEE.—The term “eligible
5 employee” means an individual employed by an em-
6 ployer, and includes the spouse and any dependent
7 of such employee. Such term also includes an em-
8 ployee within the meaning of section 401(c)(1) of
9 the Internal Revenue Code of 1986.

10 (3) ELIGIBLE INDIVIDUAL.—The term “eligible
11 individual” means an individual who is otherwise not
12 eligible for coverage under—

- 1 (A) an employer-sponsored health plan, or
2 (B) the medicare program under title
3 XVIII of the Social Security Act.

4 The term “eligible individual” includes the spouse
5 and any dependent of such individual unless such
6 spouse or dependent is not an eligible individual.

7 (4) ELIGIBLE SMALL EMPLOYER.—The term
8 “eligible small employer” means, with respect to a
9 calendar year, an employer that normally employs
10 more than 1 but less than 51 employees on a typical
11 business day. For the purposes of this paragraph,
12 the term “employee” includes a self-employed indi-
13 vidual.

14 (5) HEALTH PLAN.—The term “health plan”
15 (including self-insured plans) means any hospital or
16 medical service policy or certificate, hospital or medi-
17 cal service plan contract, or health maintenance or-
18 ganization group contract and, in States which have
19 distinct licensure requirements, a multiple employer
20 welfare arrangement, but does not include any of the
21 following offered by an insurer—

- 22 (A) accident only, dental only, disability
23 only insurance, or long-term care only insur-
24 ance;

1 (B) coverage issued as a supplement to li-
2 ability insurance or Medicare;

3 (C) workmen's compensation or similar in-
4 surance; or

5 (D) automobile medical-payment insur-
6 ance.

7 (6) INSURER.—The term “insurer” means any
8 person that offers a health plan to an eligible small
9 employer or eligible individual.

10 (7) SECRETARY.—The term “Secretary” means
11 the Secretary of Health and Human Services.

12 **TITLE I—IMPROVING PRIVATE**
13 **HEALTH INSURANCE**
14 **Subtitle A—Federal and State**
15 **Roles**

16 **SEC. 101. FEDERAL REFORM AND STATE IMPLEMENTA-**
17 **TION.**

18 (a) CERTIFICATION OF STATE HEALTH REFORM
19 PROGRAMS.—

20 (1) CERTIFICATION.—The Secretary shall es-
21 tablish by regulation a process by which each State
22 shall submit a health reform program to the Sec-
23 retary, and the Secretary shall determine and certify
24 whether such State program is consistent with the
25 requirements of section 103.

1 (2) PERIODIC REVIEW.—The Secretary may,
2 from time-to-time, review a State program after
3 such program has been originally certified to ensure
4 continued compliance with section 103 and may de-
5 certify such program based on such review.

6 **SEC. 102. APPLICABLE REGULATORY AUTHORITY FOR**
7 **HEALTH PLANS.**

8 (a) IN GENERAL.—Except as provided in subsection
9 (b), each State shall ensure that health plans offered to
10 individuals residing in such State meet the requirements
11 of this Act, including sections 111 and 112, as applicable.

12 (b) EXCEPTIONS.—

13 (1) ERISA PLANS.—The Secretary of Labor
14 shall ensure that health plans established pursuant
15 to the requirements of the Employee Retirement In-
16 come Security Act of 1974 (29 U.S.C. 1001 et seq.)
17 meet the requirements under section 112 for AHPs.

18 (2) INADEQUATE STATE PLANS.—The Secretary
19 shall ensure that health plans in a State meet the
20 requirements of sections 111 and 112, as applicable,
21 if the Secretary does not certify the health reform
22 program submitted by such State or if the Secretary
23 decertifies the State's program.

1 (c) EFFECTIVE DATE.—The requirements of this
2 title shall apply to health plans offered, issued, or renewed
3 on or after the later of—

4 (1) January 1, 1996; or

5 (2) in the case of a State which the Secretary
6 identifies as requiring State legislation in order to
7 implement this title, the first day of the first cal-
8 endar quarter beginning after the close of the first
9 regular legislative session of the State legislature
10 that begins after enactment of this Act, but not be-
11 fore January 1, 1996.

12 For purposes of the previous sentence, in the case of a
13 State that has a 2-year legislative session, each year of
14 such session shall be deemed to be a regular legislative
15 session of the State legislature.

16 **SEC. 103. STATE HEALTH REFORM PROGRAM REQUIRE-**
17 **MENTS.**

18 (a) IN GENERAL.—To be certified by the Secretary
19 as meeting the requirements of this section, a State health
20 reform program must include the following requirements,
21 in addition to any other requirements established by the
22 Secretary by regulation for carrying out this Act:

23 (1) HEALTH PLAN MARKET AREAS.—A State
24 shall establish health plan market areas, ensuring
25 that—

1 (A) every resident resides within 1 such
2 market area based on place of residence;

3 (B) market areas do not overlap;

4 (C) a metropolitan statistical area is not
5 included in more than 1 such market area; and

6 (D) the maximum number of State resi-
7 dents have the opportunity to select from com-
8 peting health plans and AHPs that are likely to
9 be available in such market areas.

10 (2) INTERSTATE COORDINATION.—A State shall
11 coordinate its health reform program with the pro-
12 grams of bordering and nearby States so that—

13 (A) 1 health plan market area covers a
14 metropolitan statistical area which crosses State
15 borders; and

16 (B) residents of a State may have access
17 to providers of health care services of bordering
18 or nearby States.

19 (3) HEALTH PLAN REGULATION.—A State shall
20 ensure that certified health plans and AHPs offered
21 to residents of the State (other than those plans reg-
22 ulated by the Secretary of Labor under section
23 102(b)(1)) meet the requirements of section 111 and
24 112, respectively.

1 (4) NO BENEFIT MANDATES, ANTIMANAGED
2 CARE REQUIREMENTS.—A State shall ensure that
3 AHPs are not—

4 (A) required to cover any service in the
5 standard benefits package not otherwise re-
6 quired by the Secretary under section 113;

7 (B) prohibited or limited from including fi-
8 nancial incentives for enrollees to use the serv-
9 ices of participating providers;

10 (C) prohibited or limited from restricting
11 coverage of services to those—

12 (i) provided by a participating pro-
13 vider; or

14 (ii) authorized by a designated partici-
15 pating provider;

16 (D) restricted in the amount of payment
17 made to participating providers for services pro-
18 vided to enrollees or restricted in the ability of
19 such AHPs to pay participating providers for
20 services provided to enrollees on a per-enrollee
21 basis;

22 (E) prohibited or limited from restricting
23 the location, number, type, or professional
24 qualifications of participating providers;

1 (F) prohibited or limited from requiring
2 that services be authorized by a primary care
3 physician selected by the enrollee from a list of
4 available participating providers;

5 (G) prohibited or limited in the use of uti-
6 lization review procedures or criteria;

7 (H) required to make public utilization re-
8 view procedures or criteria;

9 (I) prohibited or limited from determining
10 the location or hours of operation of a utiliza-
11 tion review, provided that emergency services
12 furnished during the hours in which the utiliza-
13 tion review program is not open are not subject
14 to utilization review;

15 (J) required to pay providers for the ex-
16 penses associated with responding to requests
17 for information needed to conduct utilization re-
18 view;

19 (K) restricted in the amount of payment
20 made for the conduct of utilization review;

21 (L) restricted in the access to medical in-
22 formation or personnel required to conduct uti-
23 lization review;

1 (M) required to define utilization review as
2 the practice of medicine or another health care
3 profession; or

4 (N) required to ensure that utilization re-
5 view be conducted—

6 (i) by a resident of the State in which
7 the treatment is to be offered or by an in-
8 dividual licensed in such State, or

9 (ii) by a physician in any particular
10 specialty or with any board certified spe-
11 cialty of the same medical specialty as the
12 provider whose services are being rendered.

13 (5) SMALL BUSINESS PURCHASING POOL.—

14 (A) IN GENERAL.—A State shall ensure
15 that small group purchasing pools meet the re-
16 quirements of section 121.

17 (B) STATE-SPONSORED POOLS.—If, any
18 market area established by the State (or market
19 area that is within the borders of more than 1
20 State) does not have a small group purchasing
21 group in operation that meets the requirements
22 of section 121, the State shall sponsor such a
23 pool meeting the requirements of section 121.

1 (6) HEALTH DISCOUNT PROGRAM.—A State
2 shall establish a health discount program meeting
3 the requirements of part I of subtitle B of title III.

4 (7) MEDICAL LIABILITY REFORM.—A State
5 shall ensure that medical liability laws in the State
6 meet the requirements of subtitle A of title V.

7 (b) STATE FLEXIBILITY.—

8 (1) IN GENERAL.—The Secretary shall ensure
9 that State health reform programs are consistent
10 with—

11 (A) a nationwide private health insurance
12 system;

13 (B) cost control based on cost-conscious
14 consumers and fair competition among compet-
15 ing health plans based on the cost and quality
16 of such plans; and

17 (C) freedom for residents to choose and
18 pay for health care providers and health insur-
19 ance as such residents wish.

20 (2) FLEXIBILITY.—The Secretary may allow
21 States to propose alterations to the framework of
22 this Act if such alterations are consistent with para-
23 graph (1), do not increase the Federal budget deficit
24 in any year, and—

1 (A) the State had enacted a State health
2 reform program prior to enactment of this Act
3 that supercedes provisions of this Act; or

4 (B) the State can demonstrate that provi-
5 sions of this Act do not provide sufficient access
6 to health care services for residents of a portion
7 of the State (particularly in underserved rural
8 areas) and alterations to the State health re-
9 form program will improve access without jeop-
10 ardizing the quality of health care and without
11 undue State regulation of health care providers.

12 (3) NO SINGLE PAYER PLANS.—The Secretary
13 may not certify any State health reform program
14 which proposes to create a single payer health insur-
15 ance plan in any portion of the State.

16 (c) ENFORCEMENT.—If a State does not have a cer-
17 tified State health reform program, Federal spending for
18 health discounts in the State under title III shall be lim-
19 ited to the level of Federal spending that would have oc-
20 curred in such State under title XIX of the Social Security
21 Act (42 U.S.C. 1396 et seq.) if this Act had not been en-
22 acted.

Subtitle B—Health Plan Requirements

SEC. 111. CERTIFIED HEALTH PLAN REQUIREMENTS.

(a) IN GENERAL.—To be certified as meeting the requirements of this section, a health plan shall meet the requirements of the following subsections.

(b) LIMITATION IN PREEXISTING CONDITION CLAUSES.—

(1) IN GENERAL.—To be certified as meeting the requirements of this subsection, a health plan may, subject to the succeeding provisions of this subsection, exclude coverage with respect to services related to treatment of a preexisting condition, but the period of such exclusion may not exceed 6 months. The exclusion of coverage shall not apply to services furnished to newborns.

(2) CREDITING OF PREVIOUS COVERAGE.—

(A) IN GENERAL.—A health plan shall provide that if an individual under such plan is in a period of continuous coverage (as defined in subparagraph (B)) with respect to particular services as of the date of initial coverage under such plan, any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced by

1 1 month for each month in the period of contin-
2 uous coverage.

3 (B) PERIOD OF CONTINUOUS COVERAGE.—

4 For purposes of this paragraph, the term “pe-
5 riod of continuous coverage” means, with re-
6 spect to particular services, the period begin-
7 ning on the date an individual is enrolled under
8 a health plan, titles XVIII or XIX of the Social
9 Security Act, or other health benefits arrange-
10 ment which provides benefits with respect to
11 such services and ends on the date the individ-
12 ual is not so enrolled for a continuous period of
13 more than 3 months.

14 (3) PREEXISTING CONDITION.—For purposes of
15 this subsection, the term “preexisting condition”
16 means, with respect to coverage under a health plan
17 issued, a condition which has been diagnosed or
18 treated during the 3-month period ending on the day
19 before the first date of such coverage (without re-
20 gard to any waiting period).

21 (c) SMALL GROUP MARKET REFORM.—To be cer-
22 tified as meeting the requirements of this subsection, a
23 health plan shall meet the following:

24 (1) GUARANTEED ELIGIBILITY.—

1 (A) IN GENERAL.—No health plan may ex-
2 clude from coverage—

3 (i) any eligible individual who does not
4 qualify for assistance under section 311, or

5 (ii) any eligible employee to whom
6 coverage is made available by an eligible
7 small employer.

8 (B) WAITING PERIODS.—Subparagraph
9 (A)(ii) shall not apply to any period an eligible
10 employee is excluded from coverage under the
11 health plan solely by reason of a requirement
12 applicable to all employees that a minimum pe-
13 riod of service with the eligible small employer
14 is required before the employee is eligible for
15 such coverage.

16 (2) GUARANTEED AVAILABILITY.—

17 (A) IN GENERAL.—A health plan offered
18 to any eligible small employer or eligible indi-
19 vidual in a health plan market area shall be
20 made available to all eligible small employers
21 and eligible individuals in the health plan mar-
22 ket area.

23 (B) STATE OPTION.—To ensure availabil-
24 ity, each State may require all health plans of-
25 fered to eligible small employers or eligible indi-

viduals in a health plan market area be made available through small group purchasing pools, and that such pools be open to all eligible small employers and eligible individuals.

(3) GUARANTEED RENEWABILITY.—

(A) IN GENERAL.—A health plan issued to an eligible small employer or eligible individual shall be renewed, at the option of the eligible small employer or eligible individual, unless the plan is terminated for a reason specified in subparagraph (B) or (C).

(B) TERMINATION OF SMALL EMPLOYER OR INDIVIDUAL BUSINESS.—An insurer is not required to renew a health plan with respect to an eligible small employer or such an eligible individual, as the case may be, if the insurer—

(i) elects not to renew all of its health plans issued to eligible small employers or eligible individuals, as the case may be, in a health plan market area; and

(ii) provides notice to the applicable regulatory authority in the State and to each eligible small employer or eligible individual covered under a plan of such ter-

1 mination at least 180 days before the date
2 of expiration of the plan.

3 In the case of such a termination, the insurer
4 may not provide for issuance of any health in-
5 surance plan to an eligible small employer or el-
6 igible individual, as the case may be, in the
7 State during the 5-year period beginning on the
8 date of termination of the last plan not so re-
9 newed.

10 (C) GROUNDS FOR REFUSAL TO RENEW.—

11 (i) IN GENERAL.—An insurer may
12 refuse to renew, or may terminate, a
13 health plan only for—

14 (I) nonpayment of premiums,

15 (II) fraud or misrepresentation,

16 or

17 (III) failure to maintain mini-
18 mum participation rates (consistent
19 with clause (ii).

20 (ii) MINIMUM PARTICIPATION
21 RATES.—An insurer may require, with re-
22 spect to a health plan issued to an eligible
23 small employer, that a minimum percent-
24 age of eligible employees who do not other-
25 wise have health plan coverage are enrolled

1 in such plan if such percentage is applied
2 uniformly to all plans offered to employers
3 of comparable size.

4 (4) PREMIUMS.—

5 (A) LIMITATION ON PREMIUM VARI-
6 ATION.—

7 (i) IN GENERAL.—The premium
8 charged by an insurer for each type of ben-
9 efits package offered as a certified health
10 plan to any eligible employee or eligible in-
11 dividual in a health plan market area with-
12 in a class of family enrollment and age
13 band may not exceed the premium charged
14 for the same benefits package offered to
15 any other eligible employee or eligible indi-
16 vidual by more than 20 percent.

17 (ii) ENROLLMENT CLASS.—For pur-
18 poses of this subparagraph, the classes of
19 family enrollment are—

20 (I) individual;

21 (II) couple;

22 (III) individual with children;

23 and

24 (IV) couple with children.

1 (iii) AGE BANDS.—The Secretary shall
2 establish appropriate age bands with re-
3 spect to principal enrollees for determining
4 the compliance with this subparagraph.

5 (B) RISK ADJUSTMENTS.—

6 (i) IN GENERAL.—Premiums paid to
7 health plans offered in the small group
8 market in a health plan market area shall
9 be adjusted to reflect the relative risk of
10 enrollees in such plan compared to all eligi-
11 ble employees and eligible individuals in
12 the health plan market area.

13 (ii) MODEL PROGRAMS.—The Sec-
14 retary shall establish model risk adjust-
15 ment programs that States may adopt to
16 ensure compliance with clause (i).

17 (d) PARITY COVERAGE OF SEVERE MENTAL ILL-
18 NESSES.—

19 (1) IN GENERAL.—To be certified as meeting
20 the requirements of this subsection, a health plan
21 shall provide parity coverage for all severe mental ill-
22 nesses (as defined in regulations by the Secretary),
23 including parity cost-sharing for services necessary
24 to treat such illnesses.

25 (2) DEFINITION.—

1 (A) IN GENERAL.—Except as provided in
2 subparagraph (B), for purposes of paragraph
3 (1), the Secretary shall define severe mental ill-
4 ness through diagnosis, disability, and duration,
5 and include in such definition the following dis-
6 orders with psychotic symptoms:

7 (i) Schizophrenia.

8 (ii) Schizoaffective disorder.

9 (iii) Manic depressive disorder.

10 (iv) Autism.

11 (v) Severe forms of other disorders
12 such as major depression, panic disorder,
13 and obsessive compulsive disorder.

14 (B) CHILDREN.—For purposes of para-
15 graph (1), the Secretary shall define severe
16 mental illness for individuals under age 22 to
17 also include—

18 (i) psychotic disorders;

19 (ii) attention deficit hyperactivity dis-
20 order;

21 (iii) autism and pervasive development
22 disorder;

23 (iv) severe childhood eating disorders;

24 (v) Tourette's syndrome; and

1 (vi) any behavioral disorder that
2 would result in conduct which may place
3 the individual or another individual in dan-
4 ger of death or serious bodily injury.

5 (3) DIAGNOSIS.—For purposes of paragraph
6 (1), services necessary to properly diagnose an indi-
7 vidual's mental health disorder shall be considered
8 services necessary to treat a severe mental illness.

9 **SEC. 112. ADDITIONAL REQUIREMENTS FOR ACCOUNTABLE**
10 **HEALTH PLANS.**

11 (a) CERTIFICATION.—To be certified as an AHP, a
12 health plan must meet the requirements of the following
13 subsections of this section in addition to the requirements
14 of section 111.

15 (b) GENERAL REQUIREMENTS.—A health plan
16 shall—

17 (1) provide all medically necessary and effective
18 health benefits (as covered by the benefits package
19 specified in an AHP contract) for a fixed premium
20 for each enrollee for a specified period of time; and

21 (2) collect and report to the plan's enrollees and
22 the general public objective measures of the quality
23 of the plan's health care, the impact of the plan's
24 health care on the health status of enrollees, and en-

1 rollee satisfaction with the plan’s cost, quality, and
2 service.

3 (c) CAPACITY LIMITS AND NONDISCRIMINATION.—

4 (1) IN GENERAL.—A health plan may apply to
5 the applicable regulatory authority to impose a limit
6 on enrollment if enrollment beyond the limit is—

7 (A) not discriminatory and is based on a
8 “first-come, first-served” enrollment policy, and

9 (B) is necessary to ensure quality of care
10 for enrollees.

11 (2) PROHIBITION OF DISCRIMINATION BASED
12 ON HEALTH STATUS.—A health plan may not deny,
13 limit, or condition the coverage under (or benefits
14 of) the plan based on the health status of the indi-
15 vidual, claims experience of an individual, receipt of
16 health care by an individual, receipt of public sub-
17 sidies by an individual, lack of evidence of insurabil-
18 ity of an individual, or any other characteristic of an
19 individual that may relate to the utilization of health
20 care services.

21 (3) SERVICE AREAS.—A health plan may not
22 discriminate in the drawing of service area bound-
23 aries on the basis of race, ethnicity, socio-economic
24 status, age, or anticipated need for health services.

1 (d) ADJUSTED COMMUNITY RATING IN THE SMALL
2 GROUP MARKET.—

3 (1) IN GENERAL.—A health plan shall charge a
4 standard premium for each type of benefits package
5 offered to eligible employees of eligible small employ-
6 ers and eligible individuals in a health plan market
7 area, but may elect to adjust the premium for the
8 class of family enrollment and the age of the prin-
9 cipal enrollee.

10 (2) EXEMPTION FOR SMALL GROUP PURCHAS-
11 ING POOLS.—The standard premium charged for a
12 health plan offered to eligible employees of eligible
13 small employers and eligible individuals through a
14 small group purchasing pool may be lower than the
15 premium required pursuant to paragraph (1) if at
16 least 30 percent of all health plan premiums paid in
17 the small group market in the health plan market
18 area are made through such a pool.

19 (3) ENROLLMENT CLASS.—For purposes of this
20 subsection, the classes of family enrollment are—

21 (A) individual;

22 (B) couple;

23 (C) individual with children; and

24 (D) couple with children.

1 (4) AGE BANDS.—The Secretary may establish
2 appropriate age bands with respect to principal en-
3 rollees for determining the compliance with this sub-
4 section.

5 (e) QUALITY ASSURANCE.—

6 (1) INTERNAL QUALITY ASSURANCE AND QUAL-
7 ITY IMPROVEMENT PROGRAM.—A health plan offer-
8 ing covered services that must or may be obtained
9 from participating providers must administer an in-
10 ternal quality assurance and quality improvement
11 program that—

12 (A) meets the following criteria:

13 (i) Is clearly identified and fully ex-
14 plained to all participants in the program.

15 (ii) Is coordinated with other medical
16 management activities.

17 (iii) Communicates findings to provid-
18 ers and consumers with the primary goal
19 of improving care outcomes.

20 (iv) Measures the impact of such find-
21 ings on the care delivered by providers.

22 (v) Documents the monitoring and
23 evaluation of the quality of care to identify
24 areas for improvement.

1 (vi) Develops and implements explicit
2 strategies to improve care.

3 (vii) Collects and analyzes data to fa-
4 cilitate evaluation of improvement strate-
5 gies.

6 (viii) Measures the effect of such
7 strategies on care outcomes and the quality
8 of care.

9 (ix) Incorporates a credentialing proc-
10 ess that encompasses initial credentialing,
11 recredentialing, recertifying or reappoint-
12 ment of providers, or both.

13 (x) Is accountable directly to the gov-
14 erning body of the AHP or, in instances in
15 which the governing body's participation in
16 quality assurance is not direct, to a des-
17 ignated committee of senior management;
18 or

19 (B) is accredited by an independent orga-
20 nization, such as the National Committee for
21 Quality Assurance, that conducts objective qual-
22 ity reviews based upon comparable criteria.

23 (2) MEASURING AND COMPARING QUALITY.—

24 (A) IN GENERAL.—A health plan shall
25 comply with a process, established by the Sec-

1 retary by regulation, by which such plan shall
2 provide to the appropriate regulatory authority
3 (in an electronic form) standardized informa-
4 tion necessary to—

5 (i) objectively measure and evaluate
6 the performance of such plan;

7 (ii) fairly compare the performance of
8 such plan with other AHPs; and

9 (iii) assess the health status of enroll-
10 ees in such plan to allow fair risk adjust-
11 ments among competing AHPs.

12 (B) REQUIRED DATA.—The Secretary shall
13 establish by regulation the necessary informa-
14 tion such plan must provide, including—

15 (i) quality measures, especially meas-
16 ures of health outcomes, including the clin-
17 ical health, functional status, and well
18 being of enrollees before and after treat-
19 ments and other services provided by the
20 plan;

21 (ii) measures of patient access and
22 satisfaction;

23 (iii) membership and utilization infor-
24 mation;

25 (iv) financial information;

1 (v) health plan management activities
2 information; and

3 (vi) any other information determined
4 to be necessary by the Secretary for ensur-
5 ing fair competition among AHPs based on
6 cost and quality.

7 (C) USE OF DATA.—

8 (i) IN GENERAL.—The Secretary shall
9 establish by regulation a process by which
10 such standardized information may be dis-
11 tributed by the appropriate regulatory au-
12 thority in a manner that promotes ac-
13 countability to AHP enrollees and fair
14 competition among AHPs based on cost
15 and quality.

16 (ii) WIDE ACCESS.—The Secretary
17 shall ensure that small business purchasing
18 pools and State health discount programs
19 have access to such information to ensure
20 fair competition among AHPs in those
21 such pools and health discount programs.

22 (iii) PATIENT CONFIDENTIALITY.—
23 The Secretary shall ensure by regulation
24 that the confidentiality of medical records
25 of individual enrollees is protected.

1 (f) MARKET CONDUCT REQUIREMENTS.—

2 (1) REQUIRED WRITTEN MATERIALS.—A health
3 plan shall provide written descriptions of the
4 plan's—

5 (A) covered benefits, services, and proce-
6 dures that clearly and fully describe any and all
7 limitations of coverage, use of participating pro-
8 viders and other limits on enrollees' use of serv-
9 ices; and

10 (B) out-of-pocket costs, including
11 copayments, deductibles, coinsurance, and es-
12 tablished aggregate maximums on out-of-pocket
13 costs.

14 (2) ADVERTISING.—All health plan advertising,
15 promotional materials, and other communications
16 with enrollees of the public must be factually accu-
17 rate and understandable to diverse populations.

18 (g) ENROLLEE GRIEVANCES.—A health plan shall
19 maintain procedures for hearing and resolving grievances
20 between the plan (and any entity or individual through
21 which the plan provides health care services) and the en-
22 rollees.

23 (h) POINT OF SERVICE PLAN.—A health plan offer-
24 ing covered services that must be obtained from participat-
25 ing providers shall make available an alternative insurance

1 plan that provides for a point of service option under
2 which an enrollee may select any licensed health care pro-
3 vider to obtain services and such a plan shall pay such
4 provider not less than 50 percent of the cost of such pro-
5 vider's services. A health plan may charge a higher pre-
6 mium for such an alternative insurance plan.

7 (i) FINANCIAL SOLVENCY.—

8 (1) IN GENERAL.—A health plan shall be re-
9 quired to demonstrate evidence of adequate capital-
10 ization and other indicators of fiscal health, includ-
11 ing—

12 (A) total assets greater than total
13 unsubordinated liabilities;

14 (B) sufficient cash flow and adequate li-
15 quidity to meet obligations as such obligations
16 become due;

17 (C) an insolvency protection plan; and

18 (D) insurance or other acceptable arrange-
19 ments to protect the health plan against liabil-
20 ity and casualty risks, including professional li-
21 ability.

22 (2) INSOLVENCY.—

23 (A) Enrollees in the health plan shall be
24 held harmless from incurring liability for any

1 fees that are the legal obligation of an insolvent
2 plan.

3 (B) A health plan offering coverage in a
4 market area in which an AHP has become in-
5 solvent shall be required to accept enrollment of
6 enrollees of such insolvent AHP, subject to ca-
7 pacity limits.

8 (j) MEDICAL LIABILITY REFORM.—A health plan
9 shall comply with requirements established pursuant to
10 section 501(d).

11 (k) ADMINISTRATIVE COST REDUCTION.—A health
12 plan shall comply with the requirements established pursu-
13 ant to subtitle C of title V.

14 (l) PARTICIPATION IN HEALTH DISCOUNT PRO-
15 GRAMS.—Except for health plans established pursuant to
16 the Employee Retirement Income Security Act of 1974
17 (29 U.S.C. 1001 et seq.), a health plan shall comply with
18 the requirements established by the State in accordance
19 with subtitle B of title III for making AHPs available to
20 individuals eligible for health discounts.

21 **SEC. 113. STANDARD BENEFITS.**

22 (a) STANDARD BENEFITS PACKAGE.—The Secretary
23 shall promulgate regulations establishing a standard bene-
24 fits package meeting the following requirements:

1 (1) COVERAGE.—The standard benefits package
2 shall cover—

3 (A) inpatient and outpatient hospital serv-
4 ices;

5 (B) physician services;

6 (C) diagnostic services and tests;

7 (D) outpatient prescription drugs;

8 (E) preventive services; and

9 (F) such other services as determined nec-
10 essary and appropriate by the Secretary.

11 (2) PARITY COVERAGE OF SEVERE MENTAL ILL-
12 NESSES.—The standard benefits package shall be
13 consistent with the requirement for parity coverage
14 of severe mental illnesses, pursuant to section
15 111(d).

16 (3) COST SHARING.—The Secretary shall estab-
17 lish for the standard benefits package—

18 (A) a cost-sharing arrangement consistent
19 with health care delivered by health mainte-
20 nance organizations, including an annual limit
21 on an enrollee's out-of-pocket expenses (exclud-
22 ing an enrollee's expenses for services provided
23 under an AHP point of service option);

24 (B) a cost-sharing arrangement consistent
25 with health care covered by fee-for-service

1 health insurance which is actuarially equivalent
2 to the arrangement established under subpara-
3 graph (A); and

4 (C) any other actuarially equivalent cost-
5 sharing arrangements consistent with other
6 health care delivery systems.

7 (b) NOMINAL COST-SHARING BENEFITS PACKAGE.—
8 For each cost-sharing arrangement established under sub-
9 section (a)(3), the Secretary shall also establish a nominal
10 cost-sharing benefits package for purposes of determining
11 health discounts for poor eligible individuals and poor eli-
12 gible employees under part I of subtitle B of title III. Such
13 benefits packages shall cover the same services as the
14 standard benefits package but with cost-sharing require-
15 ments that are not excessive for such individuals and em-
16 ployees.

17 (c) ALTERNATIVE BENEFITS PACKAGE.—For each
18 cost-sharing arrangement established under subsection
19 (a)(3), the Secretary shall also establish an alternative
20 benefits package that may be necessary for determining
21 health discounts for low income eligible individuals and
22 low income eligible employees under part I of subtitle B
23 of title III. Such alternative benefits packages shall cover
24 the same services as the standard benefits package but
25 with cost-sharing requirements that are sufficient to de-

1 crease the average actuarial value of the standard benefits
2 package by 50 percent.

3 **Subtitle C—Improved Health Plan**
4 **Delivery**

5 **SEC. 121. SMALL GROUP PURCHASING POOLS.**

6 (a) IN GENERAL.—Each small group purchasing pool
7 in a health plan market area in a State shall provide a
8 process for eligible employees of eligible small employers
9 and eligible individuals who are not entitled to health dis-
10 counts under part I of subtitle B of title III to have the
11 opportunity to select annually from among competing
12 AHPs offering the standard benefits package (and, for
13 poor eligible employees, the nominal cost-sharing benefits
14 package) at an adjusted community rate for the coverage
15 period.

16 (b) REQUIREMENTS.—Each small group purchasing
17 pool shall—

18 (1) be established as a private, not-for-profit
19 corporation serving eligible small employers and eli-
20 gible individuals in a health plan market area;

21 (2) contract with eligible small employers and
22 eligible individuals to provide services for a defined
23 period for a fixed administrative fee per coverage pe-
24 riod;

1 (3) be governed by a board of directors elected
2 by members of the pool;

3 (4) contract only with AHPs capable of provid-
4 ing coverage to the members of the pool throughout
5 the health plan market area;

6 (5) require all AHPs to offer at least the stand-
7 ard benefits package and any other package of bene-
8 fits as specified by the pool, and, if an AHP offers
9 covered services that must be obtained from partici-
10 pating providers, the alternative point of service in-
11 surance plan for such AHP;

12 (6) provide information to members concerning
13 the cost and quality of the competing AHPs offered
14 through the pool; and

15 (7) offer to provide administrative services to
16 members for the collection of premiums to be for-
17 warded to AHPs.

18 (c) PROHIBITIONS.—Small group purchasing groups
19 may not—

20 (1) decline to contract with an AHP if the in-
21 surer seeks to offer to members of the pool and the
22 plan meets the requirements of subsection (b);

23 (2) decline membership to any eligible small
24 employer or eligible individual located in the health
25 plan market area;

1 (3) negotiate AHP premiums on behalf of mem-
2 bers; or

3 (4) negotiate payment rates for health care pro-
4 viders contracting with AHPs offered through the
5 pool.

6 **SEC. 122. EMPLOYER RESPONSIBILITY.**

7 (a) AHP AVAILABILITY.—

8 (1) IN GENERAL.—Each employer shall—

9 (A) offer to each eligible employee enroll-
10 ment in an AHP providing a standard benefits
11 package that serves the area in which the em-
12 ployee resides, both on an individual basis, and,
13 if applicable and at the employee's option, on a
14 family basis, and, if an AHP offers covered
15 services that must be obtained from participat-
16 ing providers, the alternative point of service in-
17 surance plan for such AHP;

18 (B) provide, at the option of the employee,
19 for deduction from wages or other compensa-
20 tion of amount of any premiums due for such
21 enrollment (taking into account the amount of
22 any employer contribution); and

23 (C) if such employer is an eligible small
24 employer, also make available an AHP provid-
25 ing the nominal cost-sharing benefits package.

1 Nothing in this paragraph shall be construed as pre-
2 venting an employer from offering, or an employee
3 from electing enrollment in, an AHP that serves the
4 area in which the employee is employed, rather than
5 the area in which the employee resides.

6 (2) SMALL EMPLOYERS.—Each eligible small
7 employer may comply with the requirements of this
8 subsection by participating in a small group pur-
9 chasing pool.

10 (b) ENFORCEMENT.—

11 (1) CIVIL MONEY PENALTIES FOR FAILURE TO
12 OFFER COVERAGE OR PROVIDE FOR WAGE DEDUC-
13 TION.—Failure to offer coverage or provide for de-
14 duction from wages required under subsection (a)(1)
15 is subject to a civil monetary penalty (not to exceed
16 \$500) for each day in which the violation continues.

17 (2) DIRECT ENFORCEMENT.—The obligation to
18 offer coverage under subsection (a) with respect to
19 an eligible employee is directly enforceable by civil
20 action by the employee. In any such action, if the
21 employee substantially prevails, the employee is enti-
22 tled to reasonable attorneys' fees.

1 **TITLE II—TAX AND**
2 **ENFORCEMENT PROVISIONS**

3 **SEC. 200. AMENDMENT OF 1986 CODE.**

4 Except as otherwise expressly provided, whenever in
5 this title an amendment or repeal is expressed in terms
6 of an amendment to, or repeal of, a section or other provi-
7 sion, the reference shall be considered to be made to a
8 section or other provision of the Internal Revenue Code
9 of 1986.

10 **Subtitle A—General Tax Provisions**

11 **SEC. 201. CERTAIN EMPLOYER HEALTH PLAN CONTRIBU-**
12 **TIONS INCLUDED IN INCOME.**

13 (a) EXCLUSION FOR EMPLOYER HEALTH PLAN CON-
14 TRIBUTIONS LIMITED TO CONTRIBUTIONS TO ACCOUNT-
15 ABLE HEALTH PLANS OR CERTIFIED HEALTH PLANS.—

16 (1) IN GENERAL.—Section 106 (relating to con-
17 tributions by employer to accident and health plans)
18 is amended to read as follows:

19 **“SEC. 106. CONTRIBUTIONS BY EMPLOYER TO HEALTH**
20 **PLANS.**

21 “Except as provided in section 91, gross income of
22 an employee does not include employer-provided coverage
23 under an accountable health plan (within the meaning of
24 section 112 of the Health Care Reform Act of 1994) or

1 employer-provided coverage under a certified health plan
 2 (within the meaning of section 111 of such Act)”.

3 (2) CLERICAL AMENDMENT.—The table of sec-
 4 tions of part III of subchapter B of chapter 1 is
 5 amended by striking the item relating to section 106
 6 and inserting the following new item:

“Sec. 106. Contributions by employer to health plans.”.

7 (b) INCLUSION IN INCOME.—

8 (1) IN GENERAL.—Part II of subchapter B of
 9 chapter 1 (relating to items specifically included in
 10 gross income) is amended by adding at the end the
 11 following new section:

12 **“SEC. 91. EXCESS EMPLOYER CONTRIBUTIONS TO HEALTH**
 13 **PLANS.**

14 “(a) GENERAL RULE.—Notwithstanding section 106,
 15 if—

16 “(1) an employee is covered by an accountable
 17 health plan or a certified health plan at any time
 18 during any month, and

19 “(2) there is an excess employer contribution
 20 with respect to the employee to such plan for such
 21 month,

22 the gross income of such employee for the taxable year
 23 which includes such month shall include an amount equal
 24 to such excess employer contribution for such month.

1 “(b) EXCESS EMPLOYER CONTRIBUTION DE-
2 FINED.—

3 “(1) IN GENERAL.—For purposes of this sec-
4 tion, the term ‘excess employer contribution’ means,
5 with respect to an employee enrolled in an account-
6 able health plan or a certified health plan for any
7 month, the excess of—

8 “(A) the employer contribution to such
9 plan for such month, over

10 “(B) the applicable percentage of the ap-
11 plicable dollar limit for such employee for such
12 month.

13 “(2) APPLICABLE DOLLAR LIMIT.—

14 “(A) IN GENERAL.—For purposes of para-
15 graph (1) and except as provided in subpara-
16 graph (B), the applicable dollar limit for an em-
17 ployee for any month is equal to—

18 “(i) in the case of individual coverage,
19 \$340,

20 “(ii) in the case of couple coverage,
21 \$690,

22 “(iii) in the case of individual with de-
23 pendent child or children coverage, \$670,
24 and

1 “(iv) in the case of couple with de-
2 pendent child or children, \$910.

3 For any calendar year beginning after 2000,
4 the dollar amounts specified in this paragraph
5 for such year shall equal the dollar amounts
6 under this paragraph for the previous calendar
7 year increased by the percentage increase in the
8 per capita Gross Domestic Product for the pre-
9 vious calendar year.

10 “(B) REDUCTION OF APPLICABLE DOLLAR
11 LIMIT.—

12 “(i) IN GENERAL.—Each dollar
13 amount contained in clauses (i), (ii), (iii),
14 and (iv) of subparagraph (A) for the cal-
15 endar year shall be reduced (but not below
16 50 percent of such dollar amount) by the
17 amount determined under clause (ii).

18 “(ii) AMOUNT OF REDUCTION.—The
19 amount determined under this clause with
20 respect to any dollar amount shall be the
21 amount which bears the same ratio to 50
22 percent of such dollar amount as the ex-
23 cess of—

24 “(I) the taxpayer’s adjusted
25 gross income (determined without re-

1 gard to this section) for the taxable
 2 year ending in the calendar year, over
 3 “(II) the applicable income
 4 amount,
 5 bears to \$25,000.

6 “(iii) APPLICABLE INCOME
 7 AMOUNT.—For purposes of clause (ii)(II),
 8 the term ‘applicable income amount’ means
 9 \$75,000 (\$50,000, in the case of a tax-
 10 payer described in section 1(c)).

11 “(3) APPLICABLE PERCENTAGE.—For purposes
 12 of paragraph (1), the applicable percentage for any
 13 taxable year—

14 “(A) in the case of an accountable health
 15 plan, is 100 percent, and

16 “(B) in the case of a certified health plan,
 17 is 100 percent reduced by 20 percentage points
 18 (but not below zero percent) for each taxable
 19 year beginning after December 31, 1996.

20 “(c) SPECIAL RULE FOR MULTIEMPLOYER HEALTH
 21 PLANS.—In the case of employer contributions with re-
 22 spect to any employee made to a multiemployer health
 23 plan on a basis other than per employee per month, the
 24 Secretary may by regulations prescribe the method of de-

1 terminating that portion of such contributions that is not
2 included in gross income of the employee.

3 “(d) OTHER DEFINITIONS AND SPECIAL RULES.—
4 For purposes of this section—

5 “(1) ACCOUNTABLE OR CERTIFIED HEALTH
6 PLAN.—The terms ‘accountable health plan’ and
7 ‘certified health plan’ have the meanings given to
8 such terms by section 106.

9 “(2) EMPLOYEE INCLUDES FORMER EM-
10 PLOYEE.—The term ‘employee’ includes a former
11 employee.

12 “(3) DETERMINATION OF EMPLOYER CON-
13 TRIBUTION.—

14 “(A) IN GENERAL.—The employer con-
15 tribution to any accountable health plan or cer-
16 tified health plan for any month shall be that
17 portion of the cost of such plan for such month
18 which is incurred by the employer.

19 “(B) SELF-INSURED PLAN MAY USE AN-
20 NUAL ESTIMATES.—An employer who maintains
21 a self-insured health plan may elect (in such
22 manner and at such time as may be provided
23 in regulations) to determine the actual employer
24 contribution under subsection (b)(1)(A) for any
25 period of not more than 12 months on the basis

1 of a reasonable estimate of the cost of providing
2 coverage for such month. To the extent prac-
3 ticable, such estimate shall be made on an actu-
4 arial basis, and in the making of any such esti-
5 mate, there shall be taken into account such
6 factors as may be required under regulations.

7 “(C) EMPLOYEES ONLY TAKEN INTO AC-
8 COUNT FOR PERIODS COVERED.—For purposes
9 of determining the employer contribution,
10 amounts shall be taken into account with re-
11 spect to an employee only for periods during
12 which such employee is covered by the plan.

13 “(4) COVERAGE FOR ONLY PART OF MONTH.—
14 If an employee is covered under an accountable
15 health plan or certified health plan for only a por-
16 tion of a month, the amount required to be included
17 under subsection (a) in the gross income of such em-
18 ployee with respect to such month shall be an
19 amount which bears the same ratio to the excess em-
20 ployer contribution for such month as such portion
21 bears to the entire month.

22 “(5) CERTAIN RELATED EMPLOYERS TREATED
23 AS 1 EMPLOYER.—Rules similar to the rules pro-
24 vided by subsections (b) and (c) of section 414 shall
25 apply.

1 “(6) MONTH.—The term ‘month’ means a cal-
2 endar month.

3 “(7) MULTIEMPLOYER HEALTH PLAN.—The
4 term ‘multiemployer health plan’ means an account-
5 able health plan which is part of an employee wel-
6 fare benefit plan (within the meaning of section 3(1)
7 of the Employee Retirement Income Security Act of
8 1974)—

9 “(A) to which more than 1 employer is re-
10 quired to contribute, and

11 “(B) which is maintained pursuant to 1 or
12 more collective bargaining agreements between
13 1 or more employee organizations and more
14 than 1 employer.”.

15 (2) CLERICAL AMENDMENT.—The table of sec-
16 tions for part II of subchapter B of chapter 1 is
17 amended by adding at the end the following:

“Sec. 91. Excess employer contributions to health plans.”.

18 (c) EMPLOYMENT TAX AMENDMENTS.—

19 (1) GENERAL RULE.—Chapter 25 (relating to
20 general provisions relating to employment taxes) is
21 amended by adding at the end the following new sec-
22 tion:

1 **“SEC. 3510. TREATMENT OF EXCESS EMPLOYER CONTRIBU-**
2 **TIONS.**

3 “(a) IN GENERAL.—For purposes of this subtitle and
4 section 209 of the Social Security Act, any amount re-
5 quired to be included in the gross income of an employee
6 under section 91(a) with respect to any month—

7 “(1) shall be treated as paid in cash to such
8 employee at the close of such month, and

9 “(2) shall not be treated as paid under a health
10 or similar plan of the employer.

11 For purposes of paragraph (1), an employer may elect to
12 prorate any such amount to any payroll period (or portion
13 thereof) covering such month rather than treat it as being
14 paid at the close of such month.

15 “(b) SPECIAL RULES IN THE CASE OF SELF-IN-
16 SURED PLANS.—

17 “(1) SAFE HARBOR FOR EMPLOYEES WHOSE
18 ESTIMATES ARE AT LEAST 95 PERCENT OF ACTUAL
19 EMPLOYER CONTRIBUTIONS.—In the case of an em-
20 ployer who maintains a self-insured health plan, if
21 for any calendar year the excess of—

22 “(A) the actual employer contributions de-
23 termined under section 91 with respect to all
24 employees for such year, over

25 “(B) the amount estimated by the em-
26 ployer under section 91(d)(3)(B) as the em-

1 employer contributions with respect to all employ-
2 ees for such year,
3 is not greater than 5 percent of the amount deter-
4 mined under subparagraph (A) then, except as pro-
5 vided in paragraph (2), no penalty shall be imposed
6 under section 6672 on the employer for failure to
7 pay, or to deduct and withhold, any tax imposed by
8 this subtitle on such excess.

9 “(2) EMPLOYER MUST PAY CERTAIN TAXES ON
10 EXCESS.—Paragraph (1) shall not apply to any tax
11 imposed, or required to be deducted and withheld,
12 under sections 3111, 3221, 3301, and 3402 on the
13 excess described in paragraph (1) unless the em-
14 ployer pays any such tax within the time prescribed
15 by the Secretary under regulations.

16 “(3) SPECIAL RULES FOR EMPLOYEE’S SOCIAL
17 SECURITY TAX AND CREDIT.—In the case of the ex-
18 cess described in paragraph (1)—

19 “(A) no tax shall be imposed by section
20 3101, and

21 “(B) the amount of such excess shall not
22 be taken into account for purposes of section
23 209 of the Social Security Act.

24 “(c) LIABILITY FOR WITHHOLDING AND PAYMENT
25 OF TAX.—

1 “(1) IN GENERAL.—Except as provided in para-
 2 graph (2), the applicable payer shall withhold, and
 3 be liable for, payment of any tax required to be
 4 withheld or paid under this subtitle on any amount
 5 described in subsection (a).

6 “(2) SPECIAL RULES FOR MULTIEMPLOYER
 7 HEALTH PLANS.—In the case of any multiemployer
 8 health plan, the plan administrator shall comply
 9 with such rules with respect to the withholding of,
 10 and liability for, any tax required to be withheld or
 11 paid under this subtitle as the Secretary may require
 12 by regulations.

13 “(d) DEFINITIONS.—For purposes of this section—

14 “(1) APPLICABLE PAYER.—The term ‘applica-
 15 ble payer’ means the payer of remuneration for serv-
 16 ices which qualifies the employee for coverage under
 17 a multiemployer health plan.

18 “(2) EMPLOYEE.—The term ‘employee’ does
 19 not include a former employee.

20 “(3) MULTIEMPLOYER HEALTH PLAN.—The
 21 term ‘multiemployer health plan’ has the meaning
 22 given such term by section 91(d)(7).”.

23 (2) CLERICAL AMENDMENT.—The table of sec-
 24 tions for chapter 25 is amended by adding at the
 25 end the following new item:

“Sec. 3510. Treatment of excess employer contributions.”.

1 (d) EFFECTIVE DATES.—

2 (1) IN GENERAL.—The amendments made by
3 subsections (a) and (b) shall apply to taxable years
4 beginning after December 31, 1995.

5 (2) EMPLOYMENT TAX.—The amendments
6 made by subsection (c) shall take effect on and after
7 January 1, 1996.

8 **SEC. 202. DEDUCTIONS FOR COSTS OF HEALTH PLANS.**

9 (a) BUSINESS EXPENSE DEDUCTION FOR HEALTH
10 INSURANCE.—Section 162 (relating to trade or business
11 expenses) is amended by redesignating subsection (m) as
12 subsection (n) and by inserting after subsection (l) the fol-
13 lowing new subsection:

14 “(m) GROUP HEALTH PLANS.—The amount of ex-
15 penses paid or incurred by an employer for a group health
16 plan shall not be allowed as a deduction under this sec-
17 tion—

18 “(1) unless the plan is an accountable health
19 plan or certified health plan (as defined in section
20 106),

21 “(2) unless such employer does not vary the
22 amount incurred among plans offered to each em-
23 ployee (other than with respect to the benefits pack-
24 age and family class of enrollment coverage), and

1 “(3) with respect to each employee, to the ex-
 2 tent such amount exceeds the applicable dollar limit
 3 for such employee (within the meaning of section
 4 91(b)(2) (without regard to subparagraph (B) there-
 5 of) and determined on an annual basis).”.

6 (b) PERMANENT EXTENSION AND INCREASE IN
 7 HEALTH INSURANCE TAX DEDUCTION FOR SELF-EM-
 8 PLOYED INDIVIDUALS.—

9 (1) PERMANENT EXTENSION OF DEDUCTION.—

10 (A) IN GENERAL.—Subsection (l) of sec-
 11 tion 162 (relating to special rules for health in-
 12 surance costs of self-employed individuals) is
 13 amended by striking paragraph (6).

14 (B) EFFECTIVE DATE.—The amendment
 15 made by this paragraph shall apply to taxable
 16 years beginning after December 31, 1993.

17 (2) INCREASE IN AMOUNT OF DEDUCTION; IN-
 18 SURANCE PURCHASED MUST MEET CERTAIN STAND-
 19 ARDS.—

20 (A) INCREASE IN AMOUNT OF DEDUC-
 21 TION.—Paragraph (1) of section 162(l) is
 22 amended—

23 (i) by striking “25 percent of” and in-
 24 serting “100 percent of”, and

1 (ii) by striking “dependents.” and in-
2 serting “dependents, and only to the extent
3 such amount does not exceed the applica-
4 ble dollar limit for such taxpayer (within
5 the meaning of section 91(b)(2) and deter-
6 mined on an annual basis).”

7 (B) INSURANCE PURCHASED MUST MEET
8 CERTAIN STANDARDS.—Paragraph (2) of sec-
9 tion 162(l) is amended by adding at the end the
10 following new subparagraph:

11 “(C) INSURANCE MUST MEET CERTAIN
12 STANDARDS.—Paragraph (1) shall apply only to
13 insurance which is an accountable health plan
14 or certified health plan (as defined in section
15 106).”.

16 (C) TREATMENT OF MULTIEMPLOYER
17 HEALTH PLANS.—Subsection (l) of section 162
18 is amended by adding at the end the following
19 new paragraph:

20 “(6) TREATMENT OF MULTIEMPLOYER HEALTH
21 PLANS.—For purposes of this subsection, an amount
22 paid into a multiemployer health plan (as defined in
23 section 91(d)(7) shall be deemed to be an amount
24 paid for insurance which constitutes medical care.”.

1 (c) EFFECTIVE DATE.—Except as provided in sub-
 2 section (b)(1)(B), the amendments made by this section
 3 shall apply to taxable years beginning after December 31,
 4 1995.

5 **TITLE III—FINANCING AND RE-** 6 **FORMING FEDERAL PRO-** 7 **GRAMS**

8 **Subtitle A—Medicare**

9 **SEC. 301. MEDICARE CHOICE.**

10 (a) IN GENERAL.—Section 1876 of the Social Secu-
 11 rity Act (42 U.S.C. 1395mm) is amended to read as fol-
 12 lows:

13 “MEDICARE CHOICE

14 “SEC. 1876. (a) ESTABLISHMENT OF MEDICARE
 15 MARKET AREAS.—The Secretary shall establish various
 16 medicare market areas within the United States in such
 17 manner as to—

18 “(1) ensure that each individual entitled to ben-
 19 efits under part A and enrolled under part B, or en-
 20 rolled under part B only, resides in a medicare mar-
 21 ket area;

22 “(2) maintain all portions of each metropolitan
 23 statistical area within one medicare market area;
 24 and

25 “(3) maximize the number of such individuals
 26 who will have the opportunity for a meaningful

1 choice among competing medicare health plans
2 under contract with the Secretary under this section.

3 “(b) MEDICARE HEALTH PLANS.—

4 “(1) CONTRACTS WITH MEDICARE HEALTH
5 PLANS.—The Secretary shall enter into a contract
6 with any medicare health plan desiring to do busi-
7 ness in a medicare market area and to receive pay-
8 ment under this section, but only if the Secretary
9 certifies that such plan meets the requirements of
10 paragraph (2).

11 “(2) CERTIFICATION REQUIREMENTS.—Each
12 medicare health plan must—

13 “(A) be certified as an accountable health
14 plan by the appropriate regulatory authority
15 pursuant to title I of the Health Care Reform
16 Act of 1994;

17 “(B) except as provided in paragraph (3),
18 provide those services covered by this title
19 (hereafter in this section referred to as ‘medi-
20 care benefits’) when medically necessary for a
21 uniform monthly premium for a year;

22 “(C) not discriminate against beneficiaries
23 based on their health status, claims experience,
24 medical history, or other factors that are gen-

1 erally related with utilization of health care
2 services;

3 “(D) demonstrate the ability to provide
4 medicare benefits to all potential enrollees
5 throughout the medicare market area, unless
6 the Secretary determines it appropriate for such
7 plan to provide services to a subset of such
8 market area;

9 “(E) collect and provide such standard in-
10 formation as the Secretary shall prescribe by
11 regulation as necessary to evaluate the perform-
12 ance and quality of such plan, including en-
13 rollee satisfaction, to compare such performance
14 and quality with competing plans, and to pre-
15 pare comparative materials for distribution to
16 beneficiaries;

17 “(F) demonstrate the ability to integrate
18 additional benefits into such plan for qualified
19 medicare beneficiaries as provided in section
20 321 of the Health Care Reform Act of 1994;
21 and

22 “(G) offer the supplementary coverage
23 plans established by the Secretary under sub-
24 section (g)(3)(B).

25 “(3) COST SHARING.—

1 “(A) ACTUARIALLY EQUIVALENT MEDI-
2 CARE BENEFITS.—Each medicare health plan
3 must offer either—

4 “(i) medicare benefits, including the
5 cost-sharing requirements otherwise pro-
6 vided in this title; or

7 “(ii) actuarially equivalent medicare
8 benefits, as established by the Secretary in
9 regulations, which are medicare benefits,
10 but with cost-sharing requirements that
11 are actuarially equivalent to the cost-shar-
12 ing requirements otherwise provided in this
13 title and consistent with common practices
14 among health maintenance organizations
15 and other managed care health plans.

16 In establishing actuarially equivalent medicare
17 benefits, the Secretary shall not include in the
18 calculation any change in costs associated with
19 alternative forms of health care delivery, man-
20 agement, or utilization control.

21 “(B) OUT-OF-NETWORK COST SHARING.—
22 Each medicare health plan may require enroll-
23 ees to pay higher cost sharing for services than
24 is otherwise required by this title (or required
25 in the actuarially equivalent alternative) if—

1 “(i) the plan maintains a network of
2 providers for all medicare benefits that
3 would not require higher cost sharing; and

4 “(ii) the plan provides enrollees with
5 such information.

6 “(4) CAPACITY LIMITS.—Each medicare health
7 plan may apply to have limits placed on the number
8 of beneficiaries that may enroll in the plan in an en-
9 rollment period if the plan can demonstrate—

10 “(A) that enrolling more than the limit
11 would impair the plan’s ability to provide serv-
12 ices to other enrollees; and

13 “(B) enrollment in the plan is on a first-
14 come first-served basis, except for individuals
15 enrolled in the prior year.

16 “(c) EMPLOYER-SPONSORED HEALTH PLANS.—

17 “(1) CRITERIA FOR CERTIFICATION.—The Sec-
18 retary shall prescribe, by regulation, criteria for cer-
19 tifying medicare health plans sponsored by employ-
20 ers which will be offered only to current or former
21 employees, including requirements that such health
22 plans—

23 “(A) are certified as accountable health
24 plans pursuant to title I of the Health Care Re-
25 form Act of 1994;

1 “(B) provide benefits that cover at least
2 those services covered by this title at a premium
3 for the enrollee that does not exceed the base
4 beneficiary premium (as defined pursuant to
5 subsection (f)); and

6 “(C) are available to all eligible current
7 and former employees in the medicare market
8 area.

9 “(2) SECONDARY PAYER COVERAGE.—To be
10 certified under paragraph (1), employer-sponsored
11 health plans shall accept, at the option of individuals
12 eligible only for secondary coverage under this title
13 pursuant to section 1862(b), a fixed monthly pay-
14 ment from the Secretary to provide such individuals
15 coverage at least actuarially equivalent to the sec-
16 ondary coverage available to such individuals under
17 this title.

18 “(d) MANAGING MEDICARE CHOICE.—

19 “(1) MEDICARE HEALTH PLAN TOTAL MONTH-
20 LY PREMIUMS.—Before the beginning of each cal-
21 endar year, each medicare health plan or employer-
22 sponsored health plan under contract pursuant to
23 subsection (b) or (c) shall submit to the Secretary
24 the total monthly premium that such plan intends to
25 charge in such year.

1 “(2) ANNUAL OPEN ENROLLMENT.—

2 “(A) IN GENERAL.—The Secretary shall
3 provide for an annual open enrollment period
4 during which all individuals entitled to benefits
5 under part A and enrolled under part B, or en-
6 rolled under part B only, residing in a medicare
7 market area—

8 “(i) shall choose enrollment for the
9 next calendar year in—

10 “(I) a medicare health plan in
11 such area,

12 “(II) an employer-sponsored
13 health plan, or

14 “(III) coverage otherwise pro-
15 vided under this title (hereafter in this
16 section referred to as ‘medicare fee-
17 for-service’); and

18 “(ii) may choose supplementary bene-
19 fits offered by such health plan or a medi-
20 care supplemental policy (certified under
21 section 1882).

22 “(B) SECONDARY PAYER.—Individuals who
23 are eligible for secondary coverage under this
24 title pursuant to section 1862(b), may not en-
25 roll in a medicare health plan but may enroll in

1 an employer-sponsored health plan, to which the
2 Secretary shall make a monthly payment, pur-
3 suant to subsection (e)(2)(C).

4 “(C) PERIOD OF ENROLLMENT.—

5 “(i) IN GENERAL.—Except as pro-
6 vided in clauses (ii), (iii), and (iv), an indi-
7 vidual may not choose another enrollment
8 until the next annual period provided
9 under subparagraph (A).

10 “(ii) ENROLLMENT UPON ELIGI-
11 BILITY.—The Secretary shall provide an
12 enrollment period of 30 days to any indi-
13 vidual beginning 30 days before the date
14 such individual first becomes entitled to
15 benefits under part A or enrolled under
16 part B only. Such enrollment shall be ef-
17 fective on the date of such entitlement.

18 “(iii) TERMINATION OF PLAN.—If a
19 contract for a medicare health plan under
20 this section is terminated during any cal-
21 endar year, the Secretary shall provide for
22 an enrollment period of 30 days to any in-
23 dividual enrolled in such plan beginning on
24 the date of such termination.

1 “(iv) INDIVIDUAL NO LONGER IN
2 AREA.—An individual terminating resi-
3 dence in a medicare market area may ter-
4 minate enrollment with the medicare
5 health plan of such area as of the begin-
6 ning of the first calendar month following
7 the date on which the request is made for
8 such termination, and the Secretary shall
9 provide for an open enrollment period of
10 30 days to such individual for enrollment
11 in the new medicare market area in which
12 such individual resides beginning on the
13 date of such termination. In the case of an
14 individual’s termination of enrollment, the
15 medicare health plan shall provide the indi-
16 vidual with a copy of the written request
17 for termination of enrollment and a written
18 explanation of the period (ending on the
19 effective date of the termination) during
20 which the individual continues to be en-
21 rolled with the plan and may not receive
22 medicare benefits other than through such
23 plan.

24 “(v) EFFECTIVE DATE OF NEW EN-
25 ROLLMENT.—Enrollment under clause (iii)

1 or (iv) shall be effective 30 days after the
2 end of the enrollment period, or, if the
3 Secretary determines that such date is not
4 feasible, such other date as the Secretary
5 specifies.

6 “(D) DEFAULT ENROLLMENT.—

7 “(i) IN GENERAL.—If an individual
8 does not choose an enrollment option dur-
9 ing an enrollment period under this para-
10 graph, such individual shall be automati-
11 cally enrolled in—

12 “(I) the same option into which
13 such individual enrolled in the preced-
14 ing enrollment period; or

15 “(II) if the individual was not en-
16 rolled in such preceding period, the
17 medicare fee-for-service.

18 “(ii) NO MEDICARE HEALTH PLANS IN
19 AREA.—If there are no medicare health
20 plans in the medicare market area in
21 which the individual resides, such individ-
22 ual shall be automatically enrolled in the
23 medicare fee-for-service.

24 “(3) INFORMATION REGARDING MEDICARE OP-
25 TIONS IN MARKET AREA.—

1 “(A) IN GENERAL.—The Secretary shall
2 provide each individual making an enrollment
3 decision during any enrollment period described
4 in paragraph (2) with the following information,
5 in comparative form, regarding the medicare
6 health plans and medicare fee-for-service avail-
7 able in the medicare market area in which such
8 individual resides:

9 “(i) The individual’s premiums for
10 medicare benefits.

11 “(ii) The individual’s premiums for
12 any supplementary benefits.

13 “(iii) Enrollee restrictions.

14 “(iv) Quality information, including
15 enrollee satisfaction and health outcomes.

16 “(v) Any other necessary information
17 as determined by the Secretary.

18 “(B) MARKETING REQUIREMENTS.—The
19 Secretary shall prescribe the procedures and
20 conditions under which a medicare health plan
21 that has entered into a contract with the Sec-
22 retary under this section may inform individ-
23 uals eligible to enroll under this section with the
24 plan about the plan. No brochures, application
25 forms, or other promotional or informational

1 material may be distributed by such plan to (or
2 for the use of) individuals eligible to enroll with
3 the plan under this section unless—

4 “(i) at least 45 days before its dis-
5 tribution, the plan has submitted the mate-
6 rial to the Secretary for review;

7 “(ii) the material is made available to
8 all individuals eligible to enroll in the medi-
9 care health plan in the medicare market
10 area; and

11 “(iii) the Secretary has not dis-
12 approved the distribution of the material.

13 The Secretary shall review all such material
14 submitted and shall disapprove such material if
15 the Secretary determines, in the Secretary’s dis-
16 cretion, that the material is materially inac-
17 curate or misleading or otherwise makes a ma-
18 terial misrepresentation.

19 “(4) RISK ADJUSTMENTS.—

20 “(A) IN GENERAL.—The Secretary shall
21 adjust the payments made to medicare health
22 plans and employer-sponsored health plans
23 under this title to reflect the relative health
24 risks of classes of beneficiaries enrolled in such
25 plans in the medicare market area. The Sec-

1 retary may define appropriate classes of bene-
2 ficiaries, based on age, disability status, and
3 such other factors as the Secretary determines
4 to be appropriate, so as to ensure actuarial
5 equivalence and the efficient delivery of health
6 care. The Secretary may add to, modify, or sub-
7 stitute for such classes, if such changes will im-
8 prove the determination of actuarial equiva-
9 lence.

10 “(B) PENALTIES FOR DISCRIMINATION.—

11 The Secretary shall have the authority to im-
12 pose financial penalties on medicare health
13 plans or employer-sponsored health plans that
14 knowingly violate the prohibition against dis-
15 crimination against potential enrollees based on
16 their health status, claims experience, medical
17 history, or other factors that are generally re-
18 lated with utilization of health care services.

19 “(5) PAYMENTS TO PLANS.—

20 “(A) IN GENERAL.—The Secretary shall
21 forward to each medicare health plan or em-
22 ployer-sponsored health plan the medicare per
23 capita rate for the medicare market area, as de-
24 termined under subsection (e), for every bene-
25 ficiary enrolled in such plan for that month, ex-

cluding any beneficiary premium but reflecting any adjustments required pursuant to paragraph (4)(A).

“(B) COLLECTION OF BENEFICIARY PREMIUMS AND REBATES.—

“(i) PREMIUMS.—Each medicare health plan or employer-sponsored plan shall be responsible for collecting premiums owed by beneficiaries for enrolling in such plan, including premiums for medicare benefits and any supplementary benefits.

“(ii) REBATES.—Any medicare health plan or employer-sponsored plan which charges a total monthly premium which is less than the medicare per capita rate for an enrollee shall be responsible for paying to such enrollee a rebate equal to the excess medicare per capita rate or may use such rebate to offset any premium owed by the enrollee for any supplementary benefits selected by the enrollee.

“(C) SOURCE OF PAYMENT.—The amounts paid to medicare health plans and employer-sponsored health plans shall be made from the

1 Federal Hospital Insurance Trust Fund and
2 the Supplementary Insurance Trust Fund
3 based on an allocation determined by the Sec-
4 retary.

5 “(e) MEDICARE PER CAPITA RATE.—

6 “(1) ANNOUNCEMENT.—With respect to each
7 medicare market area, the Secretary shall announce,
8 not later than October 1 (beginning with 1995) the
9 per capita rate that will apply to such market area
10 beginning with the enrollment year (which coincides
11 with the next calendar year).

12 “(2) PER CAPITA RATE.—

13 “(A) IN GENERAL.—Except as provided in
14 subparagraphs (B) and (C), the per capita rate
15 for a medicare market area shall be equal to
16 the lesser of the maximum per capita rate or
17 the sum of—

18 “(i) the excess of—

19 “(I) the benchmark premium for
20 such area, over

21 “(II) the base beneficiary pre-
22 mium for such area; and

23 “(ii) the applicable percentage of the
24 excess of—

1 “(I) the fee-for-service per capita
 2 costs (hereafter in this section re-
 3 ferred to as ‘FFSPCC’) for such area,
 4 over

5 “(II) such benchmark premium.

6 For purposes of the preceding sentence, the ap-
 7 plicable percentage shall be determined by the
 8 following table:

“Enrollment year:	Applicable percentage:
1996	90
1997	80
1998	70
1999	60
2000 and thereafter	50.

9 “(B) SECONDARY PAYER PER CAPITA
 10 RATE.—For individuals who are eligible for sec-
 11 ondary coverage under this title pursuant to
 12 section 1862(b) and elect to enroll in an em-
 13 ployer-sponsored health plan, the Secretary
 14 shall determine a per capita rate for each medi-
 15 care market area equal to the costs of providing
 16 secondary coverage to all individuals in such
 17 market area divided by the number of individ-
 18 uals eligible for such coverage in such market
 19 area.

20 “(C) RURAL ENROLLEES.—

21 “(i) FIVE-YEAR BONUS.—For enroll-
 22 ment periods beginning in 1996 through

1 2000, the per capita rate in each medicare
2 market area (otherwise determined under
3 this paragraph) shall be increased by 10
4 percent (without regard to the maximum
5 established under paragraph (3)) with re-
6 spect to each individual enrolling in a med-
7 icare health plan or employer-sponsored
8 health plan who resides in an underserved
9 rural area within such market area, as de-
10 termined by the Secretary.

11 “(ii) IMPROVE ACCESS.—The bonus
12 amount paid under this subparagraph shall
13 be used by such health plans to improve
14 access and coordinated service delivery in
15 the underserved rural area in which the
16 enrollee resides. The bonus amount shall
17 not reduce the premiums owed by the en-
18 rollee for medicare benefits or any supple-
19 mentary coverage.

20 “(iii) STUDY AND RECOMMENDA-
21 TIONS.—The Secretary shall report to the
22 Congress at the end of the 5-year period
23 described in clause (ii) on the status of
24 health care access in underserved rural
25 areas and shall make recommendations re-

1 garding continuation of bonus per capita
2 payments.

3 “(3) MAXIMUM PER CAPITA RATE.—

4 “(A) IN GENERAL.—Except as provided in
5 subparagraph (E), the maximum per capita
6 rate in any medicare market area shall be the
7 excess of—

8 “(i) the product of—

9 “(I) FFSPCC in all medicare
10 market areas, and

11 “(II) an adjustment factor for
12 such market area; over

13 “(ii) the fee-for-service beneficiary
14 premium required pursuant to subsection
15 (f)(2)(B)(ii).

16 “(B) ADJUSTMENT FACTOR.—For pur-
17 poses of subparagraph (A)(i)(II), and except as
18 provided in subparagraph (D):

19 “(i) FFSPCC RATIO LESS THAN .8.—
20 For medicare market areas with a
21 FFSPCC ratio less than or equal to .8, the
22 adjustment factor shall be .8.

23 “(ii) FFSPCC RATIO BETWEEN .8 AND
24 .95.—For medicare market areas with a
25 FFSPCC ratio less than .95 but greater

1 than .8, the adjustment factor shall be the
2 sum of .85, plus—

3 “(I) .1, multiplied by

4 “(II) the ratio of the excess of
5 the FFSPCC ratio over .8, to .15.

6 “(iii) FFSPCC RATIO BETWEEN .95
7 AND 1.05.—For medicare market areas
8 with a FFSPCC ratio of at least .95 but
9 less than 1.05, the adjustment factor shall
10 be the FFSPCC ratio.

11 “(iv) FFSPCC RATIO BETWEEN 1.05
12 AND 1.2.—For medicare market areas with
13 a FFSPCC ratio of at least 1.05 but less
14 than 1.2, the adjustment factor shall be
15 the sum of 1.05, plus—

16 “(I) .1, multiplied by

17 “(II) the ratio of the excess of
18 the FFSPCC ratio over 1.05, to .15.

19 “(v) FFSPCC RATIO GREATER THAN
20 1.2.—For medicare market areas with a
21 FFSPCC ratio greater than or equal to
22 1.2, the adjustment factor shall be 1.2.

23 “(C) FFSPCC RATIO.—For purposes of
24 subparagraph (B), for each medicare market
25 area, the Secretary shall determine a FFSPCC

1 ratio by dividing FFSPCC in such market area
2 by FFSPCC for all medicare market areas.

3 “(D) BUDGET NEUTRALITY.—The Sec-
4 retary shall change the adjustment factors as
5 necessary to ensure that total spending under
6 this title shall not exceed the level of spending
7 that would occur if the maximum per capita
8 rate in each medicare market area were equal
9 to the FFSPCC in each such market area.

10 “(E) ALTERNATIVE FORMULA.—The Sec-
11 retary may substitute an alternative formula for
12 determining the maximum rate in each medi-
13 care market area. Such an alternative formula
14 shall generally conform to the pattern of adjust-
15 ment factors specified in subparagraph (B), ex-
16 cept that such formula shall maintain a consist-
17 ent mathematical relationship between the ad-
18 justment factor and the FFSPCC ratio in each
19 such market area in a manner that achieves
20 budget neutrality.

21 “(4) DEFINITIONS.—For purposes of this sub-
22 section:

23 “(A) BENCHMARK PREMIUM.—The bench-
24 mark premium for a medicare market area shall
25 be equal to the sum of—

1 “(i) the lowest health plan total
 2 monthly premium submitted by a medicare
 3 health plan in such area for the enrollment
 4 year; and

5 “(ii) the applicable percentage of the
 6 excess of—

7 “(I) the average of all medicare
 8 health plan total monthly premiums
 9 submitted in such area, over

10 “(II) the lowest health plan total
 11 monthly premium in such area.

12 For purposes of the preceding sentence, the ap-
 13 plicable percentage shall be determined by the
 14 following table:

“Enrollment year:	Applicable percentage:
1996	80
1997	60
1998	40
1999 and thereafter	20.

15 “(B) FEE-FOR-SERVICE PER CAPITA
 16 COSTS.—The Secretary shall determine
 17 FFSPCC for a medicare market area by divid-
 18 ing—

19 “(i) the total spending for medicare
 20 benefits (not including beneficiary cost
 21 sharing) for individuals who reside in such
 22 area, who are not enrolled in a medicare

1 health plan or employer-sponsored health
 2 plan, and who are not in secondary payer
 3 status; by

4 “(ii) the number of such individuals.

5 The Secretary shall make such other adjust-
 6 ments as may be necessary to allow an accurate
 7 comparison of FFSPCC for the medicare mar-
 8 ket area with total monthly premiums charged
 9 by medicare health plans in such area.

10 “(f) BENEFICIARY PREMIUMS.—For purposes of this
 11 section:

12 “(1) BASE BENEFICIARY PREMIUM.—The base
 13 beneficiary premium for each medicare market area
 14 shall be equal to the product of—

15 “(A) the ratio of the monthly premium de-
 16 termined under section 1839 to the national av-
 17 erage cost per beneficiary under this title in
 18 1995, as determined by the Secretary; and

19 “(B) the benchmark premium for such
 20 area.

21 “(2) MONTHLY BENEFICIARY PREMIUMS.—

22 “(A) HEALTH PLAN BENEFICIARY PRE-
 23 MIUM.—To be enrolled for coverage in a medi-
 24 care health plan during an enrollment year for

1 medicare benefits, each beneficiary shall pay a
 2 monthly premium equal to the excess of—

3 “(i) the premium charged by the plan
 4 selected by the beneficiary; over

5 “(ii) the medicare per capita rate in
 6 the medicare market area in which the
 7 beneficiary resides.

8 “(B) FEE-FOR-SERVICE BENEFICIARY PRE-
 9 MIUM.—

10 “(i) IN GENERAL.—To be enrolled for
 11 coverage in a medicare fee-for-service in a
 12 medicare market area during an enroll-
 13 ment year for medicare benefits, each ben-
 14 eficiary shall pay a monthly premium equal
 15 to the estimated FFSPCC for the medicare
 16 market area, multiplied by the ratio deter-
 17 mined under paragraph (1)(A).

18 “(g) SUPPLEMENTARY COVERAGE PLANS.—

19 “(1) IN GENERAL.—The Secretary shall ensure
 20 that all supplementary coverage plans meet the re-
 21 quirements of this subsection, in addition to any re-
 22 quirements that may be applicable under section
 23 1882.

24 “(2) COORDINATION WITH MEDICARE
 25 CHOICE.—Supplementary coverage plans may only

1 be offered to beneficiaries during the same annual
2 open enrollment period during which beneficiaries
3 select medicare coverage and must be offered to all
4 beneficiaries in the same medicare market area for
5 the same, uniform monthly premium during the en-
6 rollment period.

7 “(3) STANDARD BENEFITS.—

8 “(A) IN GENERAL.—Medicare health plans
9 may only offer standardized supplementary cov-
10 erage plans, as established by the Secretary,
11 after consultation with the National Association
12 of Insurance Commissioners.

13 “(B) REQUIRED OPTIONS.—Among the
14 standardized plans, the Secretary shall include
15 a plan—

16 “(i) covering only outpatient prescrip-
17 tion drugs; and

18 “(ii) which, together with medicare
19 benefits, would resemble coverage typically
20 offered by health maintenance organiza-
21 tions to employer groups, including an an-
22 nual out-of-pocket maximum beneficiary li-
23 ability (covering coinsurance, copayments,
24 and deductibles).

1 “(4) ONE SPONSOR.—A sponsor of supple-
2 mentary coverage may not offer such coverage to a
3 beneficiary selecting a medicare health plan from a
4 different sponsor, except that sponsors of supple-
5 mentary coverage may offer such coverage to any in-
6 dividual selecting medicare fee-for-service.

7 “(5) SURCHARGE ON CERTAIN PLANS.—Not-
8 withstanding any other provision of this section, if
9 an individual chooses to purchase a medicare supple-
10 mental policy certified pursuant to section 1882 and
11 the coverage under such policy results in increased
12 costs to the program under this title, the monthly
13 beneficiary premium otherwise applicable under this
14 section shall be increased by a surcharge actuarially
15 equivalent to such increased costs.

16 “(6) DEFINITIONS.—The term ‘supplementary
17 coverage plan’ means any health insurance coverage
18 offered by a medicare health plan or medicare sup-
19 plemental policy (as defined in section 1882) that
20 covers health care costs not covered as medicare
21 benefits and for which the enrollee must pay a pre-
22 mium.”.

23 (b) CONFORMING AMENDMENTS.—

24 (1) Section 1882(c) of the Social Security Act
25 (42 U.S.C. 1395ss(c)) is amended—

1 (A) by striking “with respect to paragraph
2 (3)” and inserting “with respect to paragraphs
3 (3) and (6)”,

4 (B) by striking “and” at the end of para-
5 graph (4),

6 (C) by striking the period at the end of
7 paragraph (5) and inserting “; and”, and

8 (D) by adding at the end the following new
9 paragraph:

10 “(6) agrees—

11 “(A) to offer such policy during the annual
12 open enrollment period specified in section
13 1876(c)(2) at a uniform monthly premium to
14 all beneficiaries in a medicare market area es-
15 tablished under section 1876(a); and

16 “(B) not to discriminate against bene-
17 ficiaries based on their health status, claims ex-
18 perience, medical history, or other factors that
19 are generally related with utilization of health
20 care services.”.

21 (2) Section 1882(s) of such Act (42 U.S.C.
22 1395ss(s)) is amended—

23 (A) by striking paragraph (2),

1 (B) by striking “paragraphs (1) and (2)”
 2 in paragraph (3) and inserting “paragraph
 3 (1)”, and

4 (C) by redesignating paragraph (3) as
 5 paragraph (2).

6 (3) Section 1839(e) of such Act (42 U.S.C.
 7 1395r(e)) is amended to read as follows:

8 “(e) Notwithstanding the provisions of subsection (a),
 9 the monthly premium for each individual enrolled under
 10 this part for each month—

11 “(1) in 1994 shall be \$41.10;

12 “(2) in 1995 shall be \$46.10; and

13 “(3) after December 1995 shall be an amount
 14 equal to 25 percent of the monthly actuarial rate for
 15 enrollees age 65 and over, as determined under sub-
 16 section (a)(1) and applicable to such month.”.

17 (c) EFFECTIVE DATE.—The amendments made by
 18 this section shall apply to contracts entered into with re-
 19 spect to calendar years beginning after December 31,
 20 1995.

21 **SEC. 302. OTHER MEDICARE PROVISIONS.**

22 (a) APPLICATION OF COMPETITIVE ACQUISITION FOR
 23 FEE-FOR-SERVICE ITEMS AND SERVICES.—

24 (1) GENERAL RULE.—Part B of title XVIII of
 25 the Social Security Act (42 U.S.C. 1395j et seq.) is

1 amended by inserting after section 1846 the follow-
2 ing:

3 “COMPETITIVE ACQUISITION FOR ITEMS AND SERVICES

4 “SEC. 1847. (a) ESTABLISHMENT OF BIDDING
5 AREAS.—

6 “(1) IN GENERAL.—The Secretary shall, in
7 each medicare market area, award a contract or con-
8 tracts for the furnishing under this part of the items
9 and services described in subsection (c) on or after
10 January 1, 1996.

11 “(2) ALTERNATIVE AREAS.—The Secretary
12 may establish areas other than medicare market
13 areas for competitive acquisition of an item or serv-
14 ice described in subsection (c), if the establishment
15 of such an area increases the availability and acces-
16 sibility of suppliers and the probability and amount
17 of savings to be realized by the use of such competi-
18 tive acquisition in such area.

19 “(b) AWARDING OF CONTRACTS IN AREAS.—

20 “(1) IN GENERAL.—The Secretary shall con-
21 duct a competition among individuals and entities
22 supplying items and services under this part for
23 each competitive acquisition area established under
24 subsection (a) for each class of items and services.

25 “(2) CONDITIONS FOR AWARDING CONTRACT.—

26 The Secretary may not award a contract to any indi-

1 vidual or entity under the competition conducted
2 pursuant to paragraph (1) to furnish an item or
3 service under this part unless the Secretary finds
4 that the individual or entity—

5 “(A) meets quality standards specified by
6 the Secretary for the furnishing of such item or
7 service; and

8 “(B) offers to furnish a total quantity of
9 such item or service that is sufficient to meet
10 the expected need within the competitive acqui-
11 sition area.

12 “(3) CONTENTS OF CONTRACT.—A contract en-
13 tered into with an individual or entity under the
14 competition conducted pursuant to paragraph (1)
15 shall specify (for all of the items and services within
16 a class)—

17 “(A) the quantity of items and services the
18 entity shall provide; and

19 “(B) such other terms and conditions as
20 the Secretary may require.

21 “(c) SERVICES DESCRIBED.—The items and services
22 to which the provisions of this section shall apply are as
23 follows:

24 “(1) Magnetic resonance imaging tests and
25 computerized axial tomography scans, including a

1 physician's interpretation of the results of such tests
2 and scans.

3 “(2) Oxygen and oxygen equipment.

4 “(3) Clinical diagnostic laboratory tests.

5 “(4) Such other items and services for which
6 the Secretary determines that the use of competitive
7 acquisition under this section will be appropriate and
8 cost-effective.”.

9 (2) ITEMS AND SERVICES TO BE FURNISHED
10 ONLY THROUGH COMPETITIVE ACQUISITION.—Sec-
11 tion 1862(a) of such Act (42 U.S.C. 1395y(a)) is
12 amended—

13 (A) by striking “or” at the end of para-
14 graph (15),

15 (B) by striking the period at the end of
16 paragraph (16) and inserting “; or”, and

17 (C) by inserting after paragraph (16) the
18 following new paragraph:

19 “(17) where such expenses are for an item or
20 service furnished in a competitive acquisition area
21 (as established by the Secretary under section
22 1847(a)) by an individual or entity other than the
23 supplier with whom the Secretary has entered into
24 a contract under section 1847(b) for the furnishing
25 of such item or service in that area, unless the Sec-

1 retary finds that such expenses were incurred in a
2 case of urgent need.”.

3 (3) REDUCTION IN PAYMENT AMOUNTS IF COM-
4 PETITIVE ACQUISITION FAILS TO ACHIEVE MINIMUM
5 REDUCTION IN PAYMENTS.—Notwithstanding any
6 other provision of title XVIII of the Social Security
7 Act (42 U.S.C. 1395 et seq.), if the establishment
8 of competitive acquisition areas under section 1847
9 of such Act (as added by paragraph (1)) and the
10 limitation of coverage for items and services under
11 part B of such title (42 U.S.C. 1395j et seq.) to
12 items and services furnished by providers with com-
13 petitive acquisition contracts under such section does
14 not result in a reduction of at least 10 percent in
15 the projected payment amount that would have ap-
16 plied to the item or service under such part B if the
17 item or service had not been furnished through com-
18 petitive acquisition under such section, the Secretary
19 shall reduce the payment amount by such percentage
20 as the Secretary determines necessary to result in
21 such a reduction.

22 (4) EFFECTIVE DATE.—The amendments made
23 by this subsection shall apply to items and services
24 furnished under part B of title XVIII of the Social

1 Security Act (42 U.S.C. 1395j et seq.) on or after
2 January 1, 1995.

3 (b) EXPANSION OF CENTERS OF EXCELLENCE.—

4 (1) IN GENERAL.—The Secretary shall use a
5 competitive process to contract with centers of excel-
6 lence for cataract surgery, coronary artery by-pass
7 surgery, and such other services as the Secretary de-
8 termines to be appropriate for individuals enrolled in
9 medicare fee-for-service. Payment under title XVIII
10 of the Social Security Act (42 U.S.C. 1395 et seq.)
11 will be made for services subject to such contracts
12 on the basis of negotiated or all-inclusive rates as
13 follows:

14 (A) The center shall cover services pro-
15 vided in a medicare market area (established
16 pursuant to section 1876(a) of the Social Secu-
17 rity Act) for years beginning with fiscal year
18 1996.

19 (B) The amount of payment made by the
20 Secretary to the center under title XVIII of the
21 Social Security Act (42 U.S.C. et seq.) for serv-
22 ices covered under the project shall be less than
23 the aggregate amount of the payments that the
24 Secretary would have made to the center for
25 such services had the project not been in effect.

1 (C) The Secretary shall make payments to
2 the center on such a basis for the following
3 services furnished to individuals enrolled in
4 medicare fee-for-service and entitled to benefits
5 under such title:

6 (i) Facility, professional, and related
7 services relating to cataract surgery.

8 (ii) Coronary artery by-pass surgery
9 and related services.

10 (iii) Such other services as the Sec-
11 retary and the center may agree to cover
12 under the agreement.

13 (2) REBATE OF PORTION OF SAVINGS.—In the
14 case of any services provided under a demonstration
15 project conducted under paragraph (1), the Sec-
16 retary shall make a payment to each individual to
17 whom such services are furnished (at such time and
18 in such manner as the Secretary may provide) in an
19 amount equal to 10 percent of the amount by
20 which—

21 (A) the amount of payment that would
22 have been made by the Secretary under title
23 XVIII of the Social Security Act (42 U.S.C.
24 1395 et seq.) to the center for such services if

1 the services had not been provided under the
2 project, exceeds

3 (B) the amount of payment made by the
4 Secretary under such title to the center for such
5 services.

6 (c) MEDICARE SECONDARY PAYER CHANGES.—

7 (1) EXTENSION OF DATA MATCH.—

8 (A) Section 1862(b)(5)(C) of the Social
9 Security Act (42 U.S.C. 1395y(b)(5)(C)) is
10 amended by striking clause (iii).

11 (B) Section 6103(l)(12) of the Internal
12 Revenue Code of 1986 is amended by striking
13 subparagraph (F).

14 (2) REPEAL OF SUNSET ON APPLICATION TO
15 DISABLED EMPLOYEES OF EMPLOYERS WITH MORE
16 THAN 100 EMPLOYEES.—Section 1862(b)(1)(B)(iii)
17 of such Act (42 U.S.C. 1395y(b)(1)(B)(iii)), as
18 amended by section 13561(b) of the Omnibus Budg-
19 et Reconciliation Act of 1993, is amended—

20 (A) in the heading, by striking “SUNSET”
21 and inserting “EFFECTIVE DATE”, and

22 (B) by striking “, and before October 1,
23 1998”.

24 (3) EXTENSION OF PERIOD FOR END STAGE
25 RENAL DISEASE BENEFICIARIES.—Section

1 1862(b)(1)(C) of such Act (42 U.S.C.
 2 1395y(b)(1)(C)), as amended by section 13561(c) of
 3 the Omnibus Budget Reconciliation Act of 1993, is
 4 amended in the second sentence by striking “and on
 5 or before October 1, 1998,”.

6 (d) REDUCTION IN UPDATE FOR INPATIENT HOS-
 7 PITAL SERVICES.—Section 1886(b)(3)(B)(i) of the Social
 8 Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)), as amended
 9 by section 13501(a)(1) of the Omnibus Budget Reconcili-
 10 ation Act of 1993, is amended—

11 (1) in subclause (XII)—

12 (A) by striking “fiscal year 1997” and in-
 13 serting “for each of the fiscal years 1997
 14 through 2000”, and

15 (B) by striking “0.5 percentage point” and
 16 inserting “2.0 percentage points”; and

17 (2) in subclause (XIII), by striking “fiscal year
 18 1998” and inserting “fiscal year 2003”.

19 (e) REDUCTION IN ADJUSTMENT FOR INDIRECT
 20 MEDICAL EDUCATION.—

21 (1) IN GENERAL.—Section 1886(d)(5)(B)(ii) of
 22 the Social Security Act (42 U.S.C.
 23 1395ww(d)(5)(B)(ii)) is amended to read as follows:

24 “(ii) For purposes of clause (i)(II), the indirect
 25 teaching adjustment factor is equal to $c * (((1 + r)$

1 to the n th power) $- 1$), where ‘ r ’ is the ratio of the
 2 hospital’s full-time equivalent interns and residents
 3 to beds and ‘ n ’ equals .405. For discharges occur-
 4 ring on or after—

5 “(I) May 1, 1986, and before October 1,
 6 1995, ‘ c ’ is equal to 1.89, and

7 “(II) October 1, 1995, ‘ c ’ is equal to
 8 0.74.”.

9 (2) NO RESTANDARDIZATION OF PAYMENT
 10 AMOUNTS REQUIRED.—Section 1886(d)(2)(C)(i) of
 11 such Act (42 U.S.C. 1395ww(d)(2)(C)(i)) is amend-
 12 ed by striking “of 1985” and inserting “of 1985,
 13 but not taking into account the amendments made
 14 by section 302(e)(1) of the Health Care Reform Act
 15 of 1994”.

16 (f) ELIMINATION OF BAD DEBT RECOGNITION FOR
 17 HOSPITAL SERVICES.—

18 (1) IN GENERAL.—Effective October 1, 1995,
 19 in making any payment to hospitals under title
 20 XVIII of the Social Security Act (42 U.S.C. 1395 et
 21 seq.), the Secretary shall discontinue payments
 22 under title XVIII of such Act to providers of service
 23 for reasonable costs relating to unrecovered costs as-
 24 sociated with unpaid deductible and coinsurance
 25 amounts incurred under such title.

1 (2) CONFORMING AMENDMENTS.—

2 (A) IN GENERAL.—(i) Subsection (c) of
3 section 4008 of the Omnibus Budget Reconcili-
4 ation Act of 1987 is repealed.

5 (ii) Section 1833 of the Social Security Act
6 (42 U.S.C. 1395l) is amended—

7 (I) in subsection (l)(5), by striking
8 subparagraph (C), and

9 (II) in subsection (r), by striking
10 paragraph (4).

11 (B) EFFECTIVE DATE.—The amendments
12 made by subparagraph (A) shall take effect on
13 October 1, 1995.

14 (g) EXTENSION OF FREEZE ON UPDATES TO ROU-
15 TINE SERVICE COSTS OF SKILLED NURSING FACILI-
16 TIES.—

17 (1) PAYMENTS BASED ON COST LIMITS.—Sec-
18 tion 1888(a) of the Social Security Act (42 U.S.C.
19 1395yy(a)) is amended by striking “112 percent”
20 each place it appears and inserting “100 percent
21 (adjusted by such amount as the Secretary deter-
22 mines to be necessary to preserve the savings result-
23 ing from the enactment of section 13503(a)(1) of
24 the Omnibus Budget Reconciliation Act of 1993)”.

1 (2) PAYMENTS DETERMINED ON PROSPECTIVE
 2 BASIS.—Section 1888(d)(2)(B) of such Act (42
 3 U.S.C. 1395yy(d)(2)(B)) is amended by striking
 4 “105 percent” and inserting “100 percent (adjusted
 5 by such amount as the Secretary determines to be
 6 necessary to preserve the savings resulting from the
 7 enactment of section 13503(b) of the Omnibus
 8 Budget Reconciliation Act of 1993)”.

9 (3) EFFECTIVE DATE.—The amendments made
 10 by paragraphs (1) and (2) shall apply to cost report-
 11 ing periods beginning on or after October 1, 1995.

12 (h) ESTABLISHMENT OF CUMULATIVE EXPENDI-
 13 TURE GOALS FOR PHYSICIAN SERVICES.—

14 (1) USE OF CUMULATIVE PERFORMANCE
 15 STANDARD.—Section 1848(f)(2) of the Social Secu-
 16 rity Act (42 U.S.C. 1395w-4(f)(2)) is amended—

17 (A) in subparagraph (A)—

18 (i) in the heading, by striking “IN
 19 GENERAL” and inserting “FISCAL YEARS
 20 1991 THROUGH 1994.—”,

21 (ii) in the matter preceding clause (i),
 22 by striking “a fiscal year (beginning with
 23 fiscal year 1991)” and inserting “fiscal
 24 years 1991, 1992, 1993, and 1994”, and

1 (iii) in the matter following clause
2 (iv), by striking “subparagraph (B)” and
3 inserting “subparagraph (C)”;

4 (B) in subparagraph (B), by striking “sub-
5 paragraph (A)” and inserting “subparagraphs
6 (A) and (B)”;

7 (C) by redesignating subparagraphs (B)
8 and (C) as subparagraphs (C) and (D); and

9 (D) by inserting after subparagraph (A)
10 the following new subparagraph:

11 “(B) FISCAL YEARS BEGINNING WITH FIS-
12 CAL YEAR 1995.—Unless Congress otherwise
13 provides, the performance standard rate of in-
14 crease, for all physicians’ services and for each
15 category of physicians’ services, for a fiscal year
16 beginning with fiscal year 1995 shall be equal
17 to the performance standard rate of increase
18 determined under this paragraph for the pre-
19 vious fiscal year, increased by the product of—

20 “(i) 1 plus the Secretary’s estimate of
21 the weighted average percentage increase
22 (divided by 100) in the fees for all physi-
23 cians’ services or for the category of physi-
24 cians’ services, respectively, under this part

1 for portions of calendar years included in
2 the fiscal year involved,

3 “(ii) 1 plus the Secretary’s estimate of
4 the percentage increase or decrease (di-
5 vided by 100) in the average number of in-
6 dividuals enrolled under this part (other
7 than HMO enrollees) from the previous fis-
8 cal year to the fiscal year involved,

9 “(iii) 1 plus the Secretary’s estimate
10 of the average annual percentage growth
11 (divided by 100) in volume and intensity of
12 all physicians’ services or of the category
13 of physicians’ services, respectively, under
14 this part for the 5-fiscal-year period ending
15 with the preceding fiscal year (based upon
16 information contained in the most recent
17 annual report made pursuant to section
18 1841(b)(2)), and

19 “(iv) 1 plus the Secretary’s estimate
20 of the percentage increase or decrease (di-
21 vided by 100) in expenditures for all physi-
22 cians’ services or of the category of physi-
23 cians’ services, respectively, in the fiscal
24 year (compared with the previous fiscal
25 year) which are estimated to result from

1 changes in law or regulations affecting the
 2 percentage increase described in clause (i)
 3 and which is not taken into account in the
 4 percentage increase described in clause (i),
 5 minus 1, multiplied by 100, and reduced by the
 6 performance standard factor (specified in sub-
 7 paragraph (C)).”.

8 (2) TREATMENT OF DEFAULT UPDATE.—

9 (A) IN GENERAL.—Section 1848(d)(3)(B)
 10 of such Act (42 U.S.C. 1395w-4(d)(3)(B)) is
 11 amended—

12 (i) in clause (i)—

13 (I) in the heading, by striking
 14 “IN GENERAL” and inserting “1992
 15 THROUGH 1996”, and

16 (II) by striking “for a year” and
 17 inserting “for 1992, 1993, 1994,
 18 1995, and 1996”; and

19 (ii) by adding after clause (ii) the fol-
 20 lowing new clause:

21 “(iii) YEARS BEGINNING WITH 1997.—

22 “(I) IN GENERAL.—The update
 23 for a category of physicians’ services
 24 for a year beginning with 1997 pro-
 25 vided under subparagraph (A) shall be

1 increased or decreased by the same
2 percentage by which the cumulative
3 percentage increase in actual expendi-
4 tures for such category of physicians'
5 services for such year was less or
6 greater, respectively, than the per-
7 formance standard rate of increase
8 (established under subsection (f)) for
9 such category of services for such
10 year.

11 “(II) CUMULATIVE PERCENTAGE
12 INCREASE DEFINED.—In subclause
13 (I), the ‘cumulative percentage in-
14 crease in actual expenditures’ for a
15 year shall be equal to the product of
16 the adjusted increases for each year
17 beginning with 1995 up to and includ-
18 ing the year involved, minus 1 and
19 multiplied by 100. In the previous
20 sentence, the ‘adjusted increase’ for a
21 year is equal to 1 plus the percentage
22 increase in actual expenditures for the
23 year.”.

24 (B) CONFORMING AMENDMENT.—Section
25 1848(d)(3)(A)(i) of such Act (42 U.S.C.

1 1395w-4(d)(3)(A)(i)) is amended by striking
 2 “subparagraph (B)” and inserting “subpara-
 3 graphs (B) and (C)”.

4 (i) LIMITATIONS ON PAYMENT FOR PHYSICIANS’
 5 SERVICES FURNISHED BY HIGH-COST HOSPITAL MEDI-
 6 CAL STAFFS.—

7 (1) IN GENERAL.—

8 (A) LIMITATIONS DESCRIBED.—Part B of
 9 title XVIII of the Social Security Act (42
 10 U.S.C. 1395j et seq.), as amended by section
 11 302(a)(1), is amended by inserting after section
 12 1848 the following new section:

13 “LIMITATIONS ON PAYMENT FOR PHYSICIANS’ SERVICES
 14 FURNISHED BY HIGH-COST HOSPITAL MEDICAL STAFFS
 15 “SEC. 1849. (a) SERVICES SUBJECT TO REDUC-
 16 TION.—

17 “(1) DETERMINATION OF HOSPITAL-SPECIFIC
 18 PER ADMISSION RELATIVE VALUE.—Not later than
 19 October 1 of each year (beginning with 1997), the
 20 Secretary shall determine for each hospital—

21 “(A) the hospital-specific per admission
 22 relative value under subsection (b)(2) for the
 23 following year; and

24 “(B) whether such hospital-specific relative
 25 value is projected to exceed the allowable aver-
 26 age per admission relative value applicable to

1 the hospital for the following year under sub-
2 section (b)(1).

3 “(2) REDUCTION FOR SERVICES AT HOSPITALS
4 EXCEEDING ALLOWABLE AVERAGE PER ADMISSION
5 RELATIVE VALUE.—If the Secretary determines
6 (under paragraph (1)) that a medical staff’s hos-
7 pital-specific per admission relative value for a year
8 (beginning with 1998) is projected to exceed the al-
9 lowable average per admission relative value applica-
10 ble to the medical staff for the year, the Secretary
11 shall reduce (in accordance with subsection (c)) the
12 amount of payment otherwise determined under this
13 part for each physician’s service furnished during
14 the year to an inpatient of the hospital by an indi-
15 vidual who is a member of the hospital’s medical
16 staff.

17 “(3) TIMING OF DETERMINATION; NOTICE TO
18 HOSPITALS AND CARRIERS.—Not later than October
19 1 of each year (beginning with 1997), the Secretary
20 shall notify the medical executive committee of each
21 hospital (as set forth in the Standards of the Joint
22 Commission on the Accreditation of Health Organi-
23 zations) of the determinations made with respect to
24 the medical staff under paragraph (1).

1 “(b) DETERMINATION OF ALLOWABLE AVERAGE
2 PER ADMISSION RELATIVE VALUE AND HOSPITAL-SPE-
3 CIFIC PER ADMISSION RELATIVE VALUES.—

4 “(1) ALLOWABLE AVERAGE PER ADMISSION
5 RELATIVE VALUE.—

6 “(A) URBAN HOSPITALS.—In the case of a
7 hospital located in an urban area, the allowable
8 average per admission relative value established
9 under this subsection for a year is equal to 125
10 percent (or 120 percent for years after 1999) of
11 the median of 1996 hospital-specific per admis-
12 sion relative values determined under paragraph
13 (2) for all hospital medical staffs.

14 “(B) RURAL HOSPITALS.—In the case of a
15 hospital located in a rural area, the allowable
16 average per admission relative value established
17 under this subsection for 1998 and each suc-
18 ceeding year, is equal to 140 percent of the me-
19 dian of the 1996 hospital-specific per admission
20 relative values determined under paragraph (2)
21 for all hospital medical staffs.

22 “(2) HOSPITAL-SPECIFIC PER ADMISSION REL-
23 ATIVE VALUE.—

24 “(A) IN GENERAL.—The hospital-specific
25 per admission relative value projected for a hos-

1 pital (other than a teaching hospital) for a cal-
 2 endar year, shall be equal to the average per
 3 admission relative value (as determined under
 4 section 1848(c)(2)) for physicians' services fur-
 5 nished to inpatients of the hospital by the hos-
 6 pital's medical staff (excluding interns and resi-
 7 dents) during the second year preceding such
 8 calendar year, adjusted for variations in case-
 9 mix and disproportionate share status among
 10 hospitals (as determined by the Secretary under
 11 subparagraph (C)).

12 “(B) SPECIAL RULE FOR TEACHING HOS-
 13 PITALS.—The hospital-specific relative value
 14 projected for a teaching hospital in a calendar
 15 year shall be equal to the sum of—

16 “(i) the average per admission relative
 17 value (as determined under section
 18 1848(c)(2)) for physicians' services fur-
 19 nished to inpatients of the hospital by the
 20 hospital's medical staff (excluding interns
 21 and residents) during the second year pre-
 22 ceding such calendar year; and

23 “(ii) the equivalent per admission rel-
 24 ative value (as determined under section
 25 1848(c)(2)) for physicians' services fur-

1 nished to inpatients of the hospital by in-
2 terns and residents of the hospital during
3 the second year preceding such calendar
4 year, adjusted for variations in case-mix,
5 disproportionate share status, and teaching
6 status among hospitals (as determined by
7 the Secretary under subparagraph (C)).
8 The Secretary shall determine such equiva-
9 lent relative value unit per admission for
10 interns and residents based on the best
11 available data for teaching hospitals and
12 may make such adjustment in the aggre-
13 gate.

14 “(C) ADJUSTMENT FOR TEACHING AND
15 DISPROPORTIONATE SHARE HOSPITALS.—The
16 Secretary shall adjust the allowable per admis-
17 sion relative values otherwise determined under
18 this paragraph to take into account the needs
19 of teaching hospitals and hospitals receiving ad-
20 ditional payments under subparagraphs (F) and
21 (G) of section 1886(d)(5). The adjustment for
22 teaching status or disproportionate share shall
23 not be less than zero.

24 “(c) AMOUNT OF REDUCTION.—The amount of pay-
25 ment otherwise made under this part for a physician’s

1 service that is subject to a reduction under subsection (a)
2 during a year shall be reduced 15 percent, in the case of
3 a service furnished by a member of the medical staff of
4 the hospital for which the Secretary determines under sub-
5 section (a)(1) that the hospital medical staff's projected
6 relative value per admission exceeds the allowable average
7 per admission relative value.

8 “(d) RECONCILIATION OF REDUCTIONS BASED ON
9 HOSPITAL-SPECIFIC RELATIVE VALUE PER ADMISSION
10 WITH ACTUAL RELATIVE VALUES.—

11 “(1) DETERMINATION OF ACTUAL AVERAGE
12 PER ADMISSION RELATIVE VALUE.—Not later than
13 October 1 of each year (beginning with 1999), the
14 Secretary shall determine the actual average per ad-
15 mission relative value (as determined pursuant to
16 section 1848(c)(2)) for the physicians' services fur-
17 nished by members of a hospital's medical staff to
18 inpatients of the hospital during the previous year,
19 on the basis of claims for payment for such services
20 that are submitted to the Secretary not later than
21 90 days after the last day of such previous year. The
22 actual average per admission shall be adjusted by
23 the appropriate case-mix, disproportionate share fac-
24 tor, and teaching factor for the hospital medical
25 staff (as determined by the Secretary under sub-

1 section (b)(2)(C)). Notwithstanding any other provi-
2 sion of this title, no payment may be made under
3 this part for any physician's service furnished by a
4 member of a hospital's medical staff to an inpatient
5 of the hospital during a year unless the hospital sub-
6 mits a claim to the Secretary for payment for such
7 service not later than 90 days after the last day of
8 the year.

9 “(2) RECONCILIATION WITH REDUCTIONS
10 TAKEN.—In the case of a hospital for which the pay-
11 ment amounts for physicians' services furnished by
12 members of the hospital's medical staff to inpatients
13 of the hospital were reduced under this section for
14 a year—

15 “(A) if the actual average per admission
16 relative value for such hospital's medical staff
17 during the year (as determined by the Secretary
18 under paragraph (1)) did not exceed the allow-
19 able average per admission relative value appli-
20 cable to the hospital's medical staff under sub-
21 section (b)(1) for the year, the Secretary shall
22 reimburse the fiduciary agent for the medical
23 staff by the amount by which payments for
24 such services were reduced for the year under

1 subsection (c), including interest at an appro-
2 priate rate determined by the Secretary;

3 “(B) if the actual average per admission
4 relative value for such hospital’s medical staff
5 during the year is less than 15 percentage
6 points above the allowable average per admis-
7 sion relative value applicable to the hospital’s
8 medical staff under subsection (b)(1) for the
9 year, the Secretary shall reimburse the fidu-
10 ciary agent for the medical staff, as a percent
11 of the total allowed charges for physicians’ serv-
12 ices performed in such hospital (prior to the
13 withhold), the difference between 15 percentage
14 points and the actual number of percentage
15 points that the staff exceeds the limit allowable
16 average per admission relative value, including
17 interest at an appropriate rate determined by
18 the Secretary; and

19 “(C) if the actual average per admission
20 relative value for such hospital’s medical staff
21 during the year exceeded the allowable average
22 per admission relative value applicable to the
23 hospital’s medical staff by 15 percentage points
24 or more, none of the withhold is paid to the fi-
25 duciary agent for the medical staff.

1 “(3) MEDICAL EXECUTIVE COMMITTEE OF A
2 HOSPITAL.—Each medical executive committee of a
3 hospital whose medical staff is projected to exceed
4 the allowable relative value per admission for a year,
5 shall have one year from the date of notification that
6 such medical staff is projected to exceed the allow-
7 able relative value per admission to designate a fidu-
8 ciary agent for the medical staff to receive and dis-
9 burse any appropriate withhold amount made by the
10 carrier.

11 “(4) ALTERNATIVE REIMBURSEMENT TO MEM-
12 BERS OF STAFF.—At the request of a fiduciary
13 agent for the medical staff, if the fiduciary agent for
14 the medical staff is owed the reimbursement de-
15 scribed in paragraph (2)(B) for excess reductions in
16 payments during a year, the Secretary shall make
17 such reimbursement to the members of the hospital’s
18 medical staff, on a pro-rata basis according to the
19 proportion of physicians’ services furnished to inpa-
20 tients of the hospital during the year that were fur-
21 nished by each member of the medical staff.

22 “(e) DEFINITIONS.—In this section, the following
23 definitions apply:

1 “(1) MEDICAL STAFF.—An individual furnish-
2 ing a physician’s service is considered to be on the
3 medical staff of a hospital—

4 “(A) if (in accordance with requirements
5 for hospitals established by the Joint Commis-
6 sion on Accreditation of Health Organiza-
7 tions)—

8 “(i) the individual is subject to by-
9 laws, rules, and regulations established by
10 the hospital to provide a framework for the
11 self-governance of medical staff activities;

12 “(ii) subject to such bylaws, rules, and
13 regulations, the individual has clinical
14 privileges granted by the hospital’s govern-
15 ing body; and

16 “(iii) under such clinical privileges,
17 the individual may provide physicians’
18 services independently within the scope of
19 the individual’s clinical privileges, or

20 “(B) if such physician provides at least one
21 service to a medicare beneficiary in such hos-
22 pital.

23 “(2) RURAL AREA; URBAN AREA.—The terms
24 ‘rural area’ and ‘urban area’ have the meaning given
25 such terms under section 1886(d)(2)(D).

1 “(3) TEACHING HOSPITAL.—The term ‘teaching
2 hospital’ means a hospital which has a teaching pro-
3 gram approved as specified in section 1861(b)(6).”.

4 (B) CONFORMING AMENDMENTS.—(i) Sec-
5 tion 1833(a)(1)(N) of such Act (42 U.S.C.
6 1395l(a)(1)(N)) is amended by inserting “(sub-
7 ject to reduction under section 1849)” after
8 “1848(a)(1)”.

9 (ii) Section 1848(a)(1)(B) of such Act (42
10 U.S.C. 1395w-4(a)(1)(B)) is amended by strik-
11 ing “this subsection,” and inserting “this sub-
12 section and section 1849,”.

13 (2) REQUIRING PHYSICIANS TO IDENTIFY HOS-
14 PITAL AT WHICH SERVICE FURNISHED.—Section
15 1848(g)(4)(A)(i) of such Act (42 U.S.C. 1395w-
16 4(g)(4)(A)(i)) is amended by striking “beneficiary,”
17 and inserting “beneficiary (and, in the case of a
18 service furnished to an inpatient of a hospital, report
19 the hospital identification number on such claim
20 form),”.

21 (3) EFFECTIVE DATE.—The amendments made
22 by this subsection shall apply to services furnished
23 on or after January 1, 1998.

24 (j) IMPOSITION OF COINSURANCE ON LABORATORY
25 SERVICES.—

1 (1) IN GENERAL.—Paragraphs (1)(D) and
 2 (2)(D) of section 1833(a) of the Social Security Act
 3 (42 U.S.C. 1395l(a)) are each amended—

4 (A) by striking “(or 100 percent” and all
 5 that follows through “the first opinion))”, and

6 (B) by striking “100 percent of such nego-
 7 tiated rate” and inserting “80 percent of such
 8 negotiated rate”.

9 (2) EFFECTIVE DATE.—The amendments made
 10 by paragraph (1) shall apply to tests furnished on
 11 or after January 1, 1995.

12 (k) REDUCTION IN ROUTINE COST LIMITS FOR
 13 HOME HEALTH SERVICES.—

14 (1) REDUCTION IN UPDATE TO MAINTAIN
 15 FREEZE IN 1996.—Section 1861(v)(1)(L)(i) of the
 16 Social Security Act (42 U.S.C. 1395x(v)(1)(L)(i)) is
 17 amended—

18 (A) in subclause (II), by striking “or” at
 19 the end,

20 (B) in subclause (III), by striking “112
 21 percent,” and inserting “and before July 1,
 22 1996, 112 percent, or”, and

23 (C) by inserting after subclause (III) the
 24 following new subclause:

1 “(IV) July 1, 1996, 100 percent (adjusted by
2 such amount as the Secretary determines to be nec-
3 essary to preserve the savings resulting from the en-
4 actment of section 13564(a)(1) of the Omnibus
5 Budget Reconciliation Act of 1993),”.

6 (2) BASING LIMITS IN SUBSEQUENT YEARS ON
7 MEDIAN OF COSTS.—

8 (A) IN GENERAL.—Section
9 1861(v)(1)(L)(i) of such Act (U.S.C.
10 1395x(v)(1)(L)(i)), as amended by paragraph
11 (1), is amended in the matter following
12 subclause (IV) by striking “the mean” and in-
13 serting “the median”.

14 (B) EFFECTIVE DATE.—The amendment
15 made by subparagraph (A) shall apply to cost
16 reporting periods beginning on or after July 1,
17 1997.

18 (l) IMPOSITION OF COPAYMENT FOR CERTAIN HOME
19 HEALTH VISITS.—

20 (1) IN GENERAL.—

21 (A) PART A.—Section 1813(a) of the So-
22 cial Security Act (42 U.S.C. 1395e(a)) is
23 amended by adding at the end the following
24 new paragraph:

1 “(5) The amount payable for home health services
2 furnished to an individual under this part shall be reduced
3 by a copayment amount equal to 10 percent of the average
4 of all per visit costs for home health services furnished
5 under this title determined under section 1861(v)(1)(L)
6 (as determined by the Secretary on a prospective basis for
7 services furnished during a calendar year), unless such
8 services were furnished to the individual during the 30-
9 day period that begins on the date the individual is dis-
10 charged as an inpatient from a hospital.”.

11 (B) PART B.—Section 1833(a)(2) of such
12 Act (42 U.S.C. 1395l(a)(2)) is amended—

13 (i) in subparagraph (A), by striking
14 “to home health services,” and by striking
15 the comma after “opinion”),

16 (ii) in subparagraph (D), by striking
17 “and” at the end,

18 (iii) in subparagraph (E), by striking
19 the semicolon at the end and inserting “;
20 and”, and

21 (iv) by adding at the end the following
22 new subparagraph:

23 “(F) with respect to home health serv-
24 ices—

25 “(i) the lesser of —

1 “(I) the reasonable cost of such
2 services, as determined under section
3 1861(v), or

4 “(II) the customary charges with
5 respect to such services,
6 less the amount a provider may charge as
7 described in clause (ii) of section
8 1866(a)(2)(A),

9 “(ii) if such services are furnished by
10 a public provider of services, or by another
11 provider which demonstrates to the satis-
12 faction of the Secretary that a significant
13 portion of its patients are low income (and
14 requests that payment be made under this
15 clause), free of charge or at nominal
16 charges to the public, the amount deter-
17 mined in accordance with section
18 1814(b)(2), or

19 “(iii) if (and for so long as) the condi-
20 tions described in section 1814(b)(3) are
21 met, the amounts determined under the re-
22 imbursement system described in such sec-
23 tion,

24 less a copayment amount equal to 10 percent of
25 the average of all per visit costs for home

1 health services furnished under this title deter-
 2 mined under section 1861(v)(1)(L) (as deter-
 3 mined by the Secretary on a prospective basis
 4 for services furnished during a calendar year),
 5 unless such services were furnished to the indi-
 6 vidual during the 30-day period that begins on
 7 the date the individual is discharged as an inpa-
 8 tient from a hospital;”.

9 (C) PROVIDER CHARGES.—Section
 10 1866(a)(2)(A)(i) of such Act (42 U.S.C.
 11 1395cc(a)(2)(A)(i)) is amended—

12 (i) by striking “deduction or coinsur-
 13 ance” and inserting “deduction, coinsur-
 14 ance, or copayment”, and

15 (ii) by striking “or (a)(4)” and insert-
 16 ing “(a)(4), or (a)(5)”.

17 (2) EFFECTIVE DATE.—The amendments made
 18 by paragraph (1) shall apply to home health services
 19 furnished on or after July 1, 1995.

20 (m) REDUCTION IN HOSPITAL OUTPATIENT SERV-
 21 ICES THROUGH ESTABLISHMENT OF PROSPECTIVE PAY-
 22 MENT SYSTEM.—

23 (1) IN GENERAL.—Section 1833(a)(2)(B) of the
 24 Social Security Act (42 U.S.C. 1395l(a)(2)(B)) is
 25 amended by striking “section 1886)—” and all that

1 follows and inserting the following: “section 1886),
 2 an amount equal to a prospectively determined pay-
 3 ment rate established by the Secretary that provides
 4 for payments for such items and services to be based
 5 upon a national rate adjusted to take into account
 6 the relative costs of furnishing such items and serv-
 7 ices in various geographic areas, except that for
 8 items and services furnished during cost reporting
 9 periods (or portions thereof) in years beginning with
 10 1995, such amount shall be equal to 90 percent of
 11 the amount that would otherwise have been deter-
 12 mined;”.

13 (2) ESTABLISHMENT OF PROSPECTIVE PAY-
 14 MENT SYSTEM.—Not later than July 1, 1995, the
 15 Secretary shall establish the prospective payment
 16 system for hospital outpatient services necessary to
 17 carry out section 1833(a)(2)(B) of the Social Secu-
 18 rity Act (as amended by paragraph (1)).

19 (3) EFFECTIVE DATE.—The amendment made
 20 by paragraph (1) shall apply to items and services
 21 furnished on or after July 1, 1995.

22 **SEC. 303. INCOME-TESTED MEDICARE PREMIUMS.**

23 (a) IN GENERAL.—Subchapter A of chapter 1 of the
 24 Internal Revenue Code of 1986 (relating to determination

1 of tax liability) is amended by adding at the end the fol-
 2 lowing new part:

3 **“PART VIII—CERTAIN MEDICARE SUBSIDIES**
 4 **RECEIVED BY HIGH-INCOME INDIVIDUALS**

“Sec. 59B. Recapture of certain medicare subsidies.

5 **“SEC. 59B. RECAPTURE OF CERTAIN MEDICARE SUBSIDIES.**

6 “(a) IMPOSITION OF RECAPTURE AMOUNT.—In the
 7 case of an individual, if the modified adjusted gross in-
 8 come of the taxpayer for the taxable year exceeds the
 9 threshold amount, such taxpayer shall pay (in addition to
 10 any other amount imposed by this subtitle) a recapture
 11 amount for such taxable year equal to the aggregate of
 12 the Medicare recapture amounts (if any) for months dur-
 13 ing such year that a premium is paid under section 1876
 14 of the Social Security Act for the coverage of the individ-
 15 ual under such title.

16 “(b) MEDICARE RECAPTURE AMOUNT FOR
 17 MONTH.—For purposes of this section, the Medicare re-
 18 capture amount for any month is the amount equal to the
 19 excess of—

20 “(1) either—

21 “(A) the total monthly premium charged
 22 by the medicare health plan in which the indi-
 23 vidual was enrolled (as determined under sec-
 24 tion 1876(d)(1) of the Social Securty Act), or

1 “(B) the fee-for-service per capita costs (as
 2 defined in section 1876(e)(4)(B) of such Act)
 3 for individuals enrolled in medicare fee-for-serv-
 4 ice during the month in the medicare market
 5 area in which the individual was residing, over
 6 “(2) the sum of—

7 “(A) the monthly beneficiary premium
 8 owed by the individual (as determined by sec-
 9 tion 1876(f)(2) of such Act), and

10 “(B) 50 percent of the benchmark pre-
 11 mium in the medicare market area in which the
 12 individual was residing (as determined under
 13 section 1876(e)(4)(A) of such Act).

14 “(c) PHASE IN OF RECAPTURE AMOUNT.—If the
 15 modified adjusted gross income of the taxpayer for any
 16 taxable year exceeds the threshold amount by less than
 17 \$25,000, the recapture amount imposed by this section for
 18 such taxable year shall be an amount which bears the
 19 same ratio to the recapture amount which would (but for
 20 this subsection) be imposed by this section for such tax-
 21 able year as such excess bears to \$25,000.

22 “(d) OTHER DEFINITIONS AND SPECIAL RULES.—
 23 For purposes of this section—

24 “(1) THRESHOLD AMOUNT.—The term ‘thresh-
 25 old amount’ means—

1 “(A) except as otherwise provided in this
2 paragraph, \$75,000,

3 “(B) \$100,000 in the case of a joint re-
4 turn, and

5 “(C) zero in the case of a taxpayer who—

6 “(i) is married (as determined under
7 section 7703) but does not file a joint re-
8 turn for such year, and

9 “(ii) does not live apart from his
10 spouse at all times during the taxable year.

11 “(2) MODIFIED ADJUSTED GROSS INCOME.—
12 The term ‘modified adjusted gross income’ means
13 adjusted gross income—

14 “(A) determined without regard to sections
15 135, 911, 931, and 933, and

16 “(B) increased by the amount of interest
17 received or accrued by the taxpayer during the
18 taxable year which is exempt from tax.

19 “(3) JOINT RETURNS.—In the case of a joint
20 return—

21 “(A) the recapture amount under sub-
22 section (a) shall be the sum of the recapture
23 amounts determined separately for each spouse,
24 and

1 “(B) subsections (a) and (c) shall be ap-
 2 plied by taking into account the combined modi-
 3 fied adjusted gross income of the spouses.

4 “(4) COORDINATION WITH OTHER PROVI-
 5 SIONS.—

6 “(A) TREATED AS TAX FOR SUBTITLE F.—
 7 For purposes of subtitle F, the recapture
 8 amount imposed by this section shall be treated
 9 as if it were a tax imposed by section 1.

10 “(B) NOT TREATED AS TAX FOR CERTAIN
 11 PURPOSES.—The recapture amount imposed by
 12 this section shall not be treated as a tax im-
 13 posed by this chapter for purposes of determin-
 14 ing—

15 “(i) the amount of any credit allow-
 16 able under this chapter, or

17 “(ii) the amount of the minimum tax
 18 under section 55.

19 “(C) TREATED AS PAYMENT FOR MEDICAL
 20 INSURANCE.—The recapture amount imposed
 21 by this section shall be treated as an amount
 22 paid for insurance covering medical care, within
 23 the meaning of section 213(d).”.

24 (b) TRANSFERS TO MEDICARE TRUST FUNDS.—

1 (1) IN GENERAL.—There are hereby appro-
2 priated to the Hospital Insurance and the Supple-
3 mental Medical Insurance Trust Funds amounts
4 equivalent to the aggregate increase in liabilities
5 under chapter 1 of the Internal Revenue Code of
6 1986 which is attributable to the application of sec-
7 tion 59B(a)(1) of such Code, as added by this sec-
8 tion.

9 (2) TRANSFERS.—The amounts appropriated
10 by paragraph (1) shall be transferred from time to
11 time (but not less frequently than quarterly) from
12 the general fund of the Treasury on the basis of es-
13 timates made by the Secretary of the Treasury of
14 the amounts referred to in paragraph (1), and shall
15 be allocated between the Hospital Insurance and the
16 Supplemental Medical Insurance Trust Funds ac-
17 cording to a formula established by the Secretary of
18 Health and Human Services. Any quarterly payment
19 shall be made on the first day of such quarter and
20 shall take into account the recapture amounts re-
21 ferred to in such section 59B(a)(1) for such quarter.
22 Proper adjustments shall be made in the amounts
23 subsequently transferred to the extent prior esti-
24 mates were in excess of or less than the amounts re-
25 quired to be transferred.

1 (c) REPORTING REQUIREMENTS.—

2 (1) Paragraph (1) of section 6050F(a) of the
3 Internal Revenue Code of 1986 (relating to returns
4 relating to social security benefits) is amended by
5 striking “and” at the end of subparagraph (B) and
6 by inserting after subparagraph (C) the following
7 new subparagraph:

8 “(D) the number of months during the cal-
9 endar year for which a premium was paid under
10 section 1876 of the Social Security Act for the
11 coverage of such individual under such part,
12 and”.

13 (2) Paragraph (2) of section 6050F(b) of such
14 Code (relating to statements to be furnished with re-
15 spect to whom information is required) is amended
16 to read as follows:

17 “(2) the information required to be shown on
18 such return with respect to such individual.”.

19 (3) Subparagraph (A) of section 6050F(c)(1) of
20 such Code (defining appropriate Federal official) is
21 amended by inserting before the comma “and in the
22 case of the information specified in subsection
23 (a)(1)(D)”.

1 (4) The heading for section 6050F of such
 2 Code is amended by inserting “**AND MEDICARE**
 3 **COVERAGE**” before the period.

4 (5) The item relating to section 6050F in the
 5 table of sections for subpart B of part III of sub-
 6 chapter A of chapter 61 is amended by inserting
 7 “and Medicare coverage” before the period.

8 (d) **WAIVER OF CERTAIN ESTIMATED TAX PEN-**
 9 **ALTIES.**—No addition to tax shall be imposed under sec-
 10 tion 6654 of the Internal Revenue Code of 1986 (relating
 11 to failure to pay estimated income tax) for any period be-
 12 fore April 16, 1997, with respect to any underpayment
 13 to the extent that such underpayment resulted from sec-
 14 tion 59B(a) of the Internal Revenue Code of 1986, as
 15 added by this section.

16 (e) **CLERICAL AMENDMENT.**—The table of parts for
 17 subchapter A of chapter 1 is amended by adding at the
 18 end thereof the following new item:

“Part VIII. Certain medicare subsidies received by high-income
 individuals.”.

19 (f) **EFFECTIVE DATE.**—The amendments made by
 20 this section shall apply to periods after December 31,
 21 1995, in taxable years ending after such date.

22 **SEC. 304. MEDICARE ADMINISTRATIVE SIMPLIFICATION.**

23 (a) **CONSOLIDATION OF PARTS A AND B.**—By not
 24 later than October 1, 1995, the Secretary shall submit to

1 the Congress a proposal to consolidate entitlement for part
 2 A of the title XVIII of the Social Security Act (42 U.S.C.
 3 1395c et seq.) and enrollment in part B of such title (42
 4 U.S.C. 1395j et seq.) into eligibility or enrollment into the
 5 entire medicare program under such title. In preparing
 6 such a proposal, the Secretary shall consider phasing in
 7 such a consolidation, and shall ensure that no beneficiary
 8 shall pay higher premiums for coverage under such pro-
 9 gram than under such program as of the date of the enact-
 10 ment of this Act.

11 (b) CONSOLIDATION OF FEE-FOR-SERVICE ADMINIS-
 12 TRATION.—

13 (1) IN GENERAL.—The Secretary shall take
 14 such steps as may be necessary to consolidate the
 15 administration (including processing systems) of
 16 parts A and B of the medicare program (under title
 17 XVIII of the Social Security Act), including medi-
 18 care supplemental policies, over a 5-year period.

19 (2) COMBINATION OF INTERMEDIARY AND CAR-
 20 RIER FUNCTIONS.—In taking such steps, the Sec-
 21 retary may contract with a single entity that com-
 22 bines the fiscal intermediary and carrier functions in
 23 each area except where the Secretary finds that spe-
 24 cial regional or national contracts are appropriate.
 25 No medicare market area (established under section

1 1876(a) of the Social Security Act) may be subject
2 to more than 1 entity.

3 (3) STREAMLINED PROCESSING SYSTEMS.—In
4 carrying out this subsection, the Secretary may en-
5 sure—

6 (A) a streamlined, standardized, and
7 paperless process for handling all fee-for-service
8 claims, and

9 (B) that payments under title XVIII of the
10 Social Security Act (42 U.S.C. 1395 et seq.)
11 are made first by the medicare program and
12 medicare supplemental policies before providers
13 can bill beneficiaries for services using stand-
14 ardized forms.

15 (4) SUPERSEDING CONFLICTING REQUIRE-
16 MENTS.—The provisions of sections 1816 and 1842
17 of the Social Security Act (42 U.S.C. 1395h and
18 1395u) (including provider nominating provisions in
19 such section 1816) are superseded to the extent re-
20 quired to carry out this subsection.

1 **Subtitle B—Health Discount and**
2 **Medicaid Reform**

3 **PART I—HEALTH DISCOUNT**

4 **SEC. 311. STATE HEALTH DISCOUNT PROGRAMS.**

5 (a) IN GENERAL.—To be certified by the Secretary
6 as meeting the requirements of this Act, each State shall
7 include within the State health reform plan a State admin-
8 istered program, consistent with this subtitle and such
9 other requirements as determined necessary by the Sec-
10 retary and issued in regulations, under which eligible per-
11 sons shall receive premium assistance (hereafter in this
12 part referred to as “health discounts”) for purchasing
13 health care coverage from AHPs.

14 (b) CATEGORIES OF ELIGIBILITY.—Persons who oth-
15 erwise meet the criteria for entitlement under this part
16 shall be divided into the following categories of eligibility:

17 (1) Eligible individuals, as defined in section
18 1(c)(3).

19 (2) Eligible employees, as defined in section
20 1(c)(2).

21 (c) SWITCHING CATEGORIES OF ELIGIBILITY.—Indi-
22 viduals and employees who are determined to be in 1 cat-
23 egory of eligibility under subsection (b) but whose cir-
24 cumstances change and cause such individuals and em-
25 ployees to fall within the other such category shall remain

1 in the category of eligibility in which such individuals and
2 employees were originally placed until the next open en-
3 rollment period under section 312(a)(2).

4 **SEC. 312. HEALTH DISCOUNT PROGRAM DESIGN.**

5 (a) ELIGIBLE INDIVIDUALS.—

6 (1) IN GENERAL.—A State health discount pro-
7 gram shall allow each eligible individual who other-
8 wise meets the requirements for entitlement under
9 this part to select from among competing AHPs in
10 the market area in which such individual resides
11 based on the price and quality of the competing
12 AHPs and to use the discount to which such individ-
13 ual is entitled only to offset the premium charged by
14 the AHP for the benefits package selected by the in-
15 dividual.

16 (2) ANNUAL OPEN ENROLLMENT.—

17 (A) IN GENERAL.—A State health discount
18 program shall provide for an annual open en-
19 rollment period during which each eligible indi-
20 vidual shall choose enrollment in an AHP to
21 which the health discount to which such individ-
22 ual is entitled shall be paid.

23 (B) ENROLLMENT UPON ELIGIBILITY.—

24 Eligible individuals shall have an open enroll-

1 ment period upon becoming eligible for a health
2 discount.

3 (C) PERIOD OF ENROLLMENT.—After se-
4 lecting an AHP during an open enrollment pe-
5 riod, an eligible individual may not choose an-
6 other AHP to which a health discount may be
7 paid until the next annual open enrollment pe-
8 riod, except that—

9 (i) an eligible individual moving to a
10 new market area in the State shall be pro-
11 vided with a new open enrollment period,
12 and

13 (ii) an eligible individual in an AHP
14 that is terminated from the health discount
15 program shall be provided with a new open
16 enrollment period.

17 (3) COMPARATIVE INFORMATION ON ENROLL-
18 MENT OPTIONS.—During an open enrollment period,
19 a State health discount program shall provide to the
20 individual such information as may be necessary to
21 ensure such individual may compare the price and
22 quality of the AHPs available in the market area, in-
23 cluding—

24 (A) premiums by type of benefits package
25 of the competing AHPs,

1 (B) any restrictions by AHPs on enrollees'
2 selection or use of health care providers and
3 services,

4 (C) quality information, including enrollee
5 satisfaction and measures of health outcomes,

6 (D) appeal rights of enrollees, and

7 (E) any other necessary information, as
8 determined by the Secretary.

9 (4) AHP BENEFITS AND PREMIUMS.—AHPs,
10 other than AHPs offered by employers as self-in-
11 sured plans under the Employee Retirement Income
12 Security Act of 1974 (29 U.S.C. 1001 et seq.), in
13 order to be certified pursuant to section 112 of this
14 Act, shall—

15 (A) agree to participate in the State health
16 discount program and make available to eligible
17 individuals—

18 (i) the standard benefits package, as
19 determined by the Secretary pursuant to
20 section 113(a),

21 (ii) the nominal cost-sharing benefits
22 package, as determined by the Secretary
23 pursuant to section 113(b), and

24 (iii) the alternative benefits package,
25 as determined by the Secretary pursuant

1 to section 113(c), if required pursuant to
2 section 313, and

3 (B) submit, for each benefits package for
4 each enrollment period, a uniform monthly pre-
5 mium for all eligible individuals in the market
6 area, allowing adjustments in such premium
7 only for those factors provided in section
8 112(d).

9 (5) DISCOUNTS.—Each eligible individual who
10 otherwise meets the criteria for entitlement under
11 this part shall be entitled to a health discount, as
12 determined under subsection (c).

13 (6) INDIVIDUAL PREMIUMS.—To enroll in an
14 AHP, an eligible individual must pay a premium
15 equal to the excess of—

16 (A) the premium charged by the AHP for
17 the benefits package selected by the individual,
18 over

19 (B) the discount to which the individual is
20 entitled.

21 (7) PAYMENTS TO AHPS.—

22 (A) IN GENERAL.—A State health discount
23 program shall collect premiums from eligible in-
24 dividuals and forward to AHPs such premiums

1 and health discounts to which such individuals
2 are entitled.

3 (B) RISK ADJUSTMENT.—

4 (i) IN GENERAL.—A State health dis-
5 count program shall adjust the health dis-
6 counts paid to the AHPs to reflect the rel-
7 ative health risks of classes of eligible indi-
8 viduals choosing to enroll in such plans in
9 a market area. The Secretary may define
10 appropriate classes of eligible individuals,
11 based on age, disability status, and such
12 other factors as the Secretary determines
13 to be appropriate.

14 (ii) PENALTIES FOR DISCRIMINA-
15 TION.—A State health discount program
16 shall have the authority to impose financial
17 penalties on AHPs that knowingly violate
18 the prohibition against discrimination
19 against potential enrollees based on their
20 health status, claims experience, medical
21 history, or other factors that are generally
22 related with utilization of health care serv-
23 ices.

24 (b) ELIGIBLE EMPLOYEES.—

1 (1) IN GENERAL.—An eligible employee who
2 otherwise meets the criteria for entitlement under
3 this part and is enrolled in an AHP in a market
4 area in a State shall get a health discount which
5 may only be used to reduce the employee's premium
6 for enrolling in such AHP.

7 (2) DISCOUNTS.—Each eligible employee who
8 otherwise meets the criteria for entitlement under
9 this part shall be entitled to a health discount, as
10 determined under subsection (c).

11 (3) PAYMENTS TO AHPS.—A State health dis-
12 count program shall forward to AHPs such health
13 discounts to which such eligible employees are enti-
14 tled.

15 (c) DETERMINING DISCOUNTS.—

16 (1) BENCHMARK.—

17 (A) IN GENERAL.—Each calendar year, a
18 State health discount program shall determine
19 benchmark monthly premiums for the calendar
20 year for each class of family enrollment within
21 each category of eligibility and within each mar-
22 ket area.

23 (B) AHP BENEFITS AND PREMIUMS.—For
24 purposes of determining discounts, AHP pre-
25 miums shall be—

1 (i) for poor eligible individuals, those
2 AHP premiums submitted pursuant to
3 subsection (a)(4)(ii),

4 (ii) for low income eligible individuals,
5 those AHP premiums submitted pursuant
6 to subsection (a)(4)(i), or, if required by
7 section 313, subsection (a)(4)(iii),

8 (iii) for poor eligible employees, those
9 AHP premiums charged for the nominal
10 cost-sharing benefits package in the small
11 group market pursuant to section 112(d),
12 and

13 (iv) for low income eligible employees,
14 those AHP premiums charged for the
15 standard benefits package in the small
16 group market pursuant to section 112(d),
17 except that AHPs may be required to es-
18 tablish separate monthly premiums for the
19 alternative benefits package pursuant to
20 section 313.

21 (C) CALCULATION.—The benchmark
22 monthly premium shall equal the sum of the
23 lowest premium charged by an AHP for the ap-
24 plicable benefits package plus the applicable
25 percentage of the excess of—

- 1 (i) the average of all monthly pre-
 2 miums charged by AHPs, over
 3 (ii) the lowest premium charged by an
 4 AHP.

5 For purposes of the preceding sentence, the ap-
 6 plicable percentage shall be determined by fol-
 7 lowing table:

Year:	Applicable percentage:
1996	80
1997	60
1998	40
1999 and thereafter	20

8 (2) POOR ELIGIBLE INDIVIDUALS AND EMPLOY-
 9 EES.—For poor eligible individuals and poor eligible
 10 employees, the amount of the discount shall be equal
 11 to the benchmark for each category of eligibility.

12 (3) LOW INCOME ELIGIBLE INDIVIDUALS AND
 13 EMPLOYEES.—For low income eligible individuals
 14 and low income eligible employees, the amount of the
 15 discount shall be equal to the benchmark for each
 16 category of eligibility multiplied by—

17 (A) 100 percent, reduced by

18 (B) each percentage point by which the eli-
 19 gible individual's or eligible employee's family
 20 adjusted total income exceeds 100 percent of
 21 the Federal poverty line.

22 (4) DEFINITIONS.—For purposes of this part:

1 (A) POOR ELIGIBLE INDIVIDUALS AND EM-
2 PLOYEES.—The terms “poor eligible individual”
3 and “poor eligible employee” mean an eligible
4 individual or eligible employee with family ad-
5 justed total income not in excess of 100 percent
6 of the Federal poverty line.

7 (B) LOW INCOME ELIGIBLE INDIVIDUALS
8 AND EMPLOYEES.—The terms “low income eli-
9 gible individual” and “low income eligible em-
10 ployee” mean an eligible individual or eligible
11 employee with family adjusted total income ex-
12 ceeding 100 percent but not 200 percent of the
13 Federal poverty line.

14 (C) FAMILY ADJUSTED TOTAL INCOME.—

15 (i) IN GENERAL.—The term “family
16 adjusted total income” means, with respect
17 to an eligible individual or eligible em-
18 ployee, the sum of the modified total in-
19 come for the individual or employee and all
20 the other eligible family members.

21 (ii) MODIFIED FAMILY INCOME.—The
22 term “modified family income” means the
23 sum of—

24 (I) the adjusted gross income (as
25 defined in section 62(a) of the Inter-

1 nal Revenue Code of 1986) of the tax-
2 payer and family members for the tax-
3 able year determined without regard
4 to sections 911, 931, and 933 of such
5 Code, determined without the applica-
6 tion of paragraphs (6) and (7) of sec-
7 tion 62(a) of such Code and without
8 the application of section 162(l) of
9 such Code, plus

10 (II) the interest received or ac-
11 crued by the taxpayer and family
12 members during such taxable year
13 which is exempt from income, plus

14 (III) the amount of social secu-
15 rity benefits (described in section
16 86(d) of such Code) which is not in-
17 cludable in gross income of the tax-
18 payer and family members under sec-
19 tion 86 of such Code.

20 (D) FEDERAL POVERTY LINE.—The term
21 “Federal poverty line” means the income offi-
22 cial poverty line as defined by the Office of
23 Management and Budget, and revised annually
24 in accordance with section 673(2) of the Omni-
25 bus Budget Reconciliation Act of 1981.

1 (d) APPLICATIONS FOR HEALTH DISCOUNTS.—

2 (1) IN GENERAL.—Any individual who seeks as-
3 sistance under this part shall submit a written appli-
4 cation to the State health discount program.

5 (2) BASIS FOR DETERMINATION.—Subject to
6 annual enforcement under subsection (e), health dis-
7 counts under this part shall be based on 4 times the
8 family adjusted total income during the 3 months
9 preceding the month in which the application is
10 filed.

11 (3) FORM AND CONTENTS.—An application for
12 assistance under this part shall be in a form and
13 manner specified by the State health discount pro-
14 gram and shall require—

15 (A) the provision of information necessary
16 to make the determinations described in sub-
17 section (b), and

18 (B) with respect to eligible employees, the
19 provision of information with respect to the
20 AHP in which the employee is enrolled (or in
21 the process of enrolling).

22 (4) VERIFICATION.—The State health discount
23 program shall provide for verification, on a sample
24 or other basis, of the information supplied in appli-
25 cations under this part.

1 (5) PENALTIES FOR INACCURATE INFORMA-
2 TION.—

3 (A) UNDERSTATED INCOME.—A State
4 health discount program shall require individ-
5 uals who knowingly understate income reported
6 in an application to pay interest on the excess
7 health discounts paid on behalf of such individ-
8 ual, in addition to repayment of the health dis-
9 count.

10 (B) MISREPRESENTATION.—A State
11 health discount program shall require individ-
12 uals who knowingly misrepresent material infor-
13 mation in an application for health discounts
14 under this part to pay \$1000 or, if greater, 3
15 times the excess health discounts paid based on
16 such material misrepresentations.

17 (e) ANNUAL ENFORCEMENT OF HEALTH DISCOUNT
18 ENTITLEMENT.—

19 (1) ANNUAL INCOME STATEMENT.—An individ-
20 ual receiving health discounts under this part in any
21 year shall file with the State health discount pro-
22 gram, by not later than April 15 of the following
23 year, a statement verifying total adjusted family in-
24 come for the taxable year ending during the previous
25 year. Such a statement shall provide information

1 necessary to determine the family adjusted total in-
2 come during the year and the number of family
3 members as of the last day of the year.

4 (2) USE OF INCOME TAX RETURNS.—The State
5 health discount program shall provide a process
6 under which the filing of a Federal income tax re-
7 turn shall constitute the filing of an income state-
8 ment under paragraph (1).

9 (3) RECONCILIATION BASED ON ACTUAL AN-
10 NUAL INCOME.—

11 (A) IN GENERAL.—Based on the informa-
12 tion reported in the statement filed under para-
13 graph (1), the State health discount program
14 shall compute the annual health discount that
15 should have been paid on behalf of the eligible
16 individual or employee.

17 (B) RECONCILIATION.—If the health dis-
18 count computed is—

19 (i) greater than the health discount
20 paid, the program shall provide for pay-
21 ment to the individual or employee an
22 amount equal to the amount of the
23 underpayment, or

24 (ii) less than the health discount paid,
25 the program shall require the individual or

1 employee to repay the excess health dis-
2 count.

3 (4) FAILURE TO FILE.—If an individual re-
4 quired to file an income statement under this sub-
5 section fails to file such a statement, the State
6 health discount program shall disqualify such indi-
7 vidual for health discounts after May 1 of such year.
8 The program shall waive the application of this dis-
9 qualification if there is established, to the satisfac-
10 tion of the program, good cause for the failure to file
11 the statement on a timely basis.

12 (5) PENALTIES.—Any individual providing false
13 information in a statement under paragraph (1) is
14 subject to criminal penalties to the same extent as
15 such penalties may be imposed under section
16 1128B(a) of the Social Security Act (42 U.S.C.
17 1320a–7b(a)) with respect to an individual described
18 in clause (ii) of such section.

19 (6) NOTICE.—A State health discount program
20 shall provide for written notice each year of the re-
21 quirement under paragraph (1) to all individuals to
22 whom the requirement applies.

23 (7) TRANSMITTAL OF INFORMATION.—The Sec-
24 retary of the Treasury shall transmit annually to the
25 State such information relating to the adjusted total

1 income of individuals for the taxable year ending in
2 the previous year as may be necessary to verify the
3 reconciliation of health discounts under this sub-
4 section.

5 (f) SMALL GROUP PURCHASING POOLS.—A State
6 may contract with small group purchasing pools to admin-
7 ister portions of the health discount program, as appro-
8 priate.

9 **SEC. 313. FINANCING HEALTH DISCOUNTS.**

10 (a) IN GENERAL.—Health discounts shall be financed
11 with—

12 (1) available Federal spending,

13 (2) required State Medicaid maintenance of ef-
14 fort spending and State matching amounts, and

15 (3) optional State supplementation.

16 (b) AVAILABLE FEDERAL SPENDING.—

17 (1) IN GENERAL.—For purposes of subsection

18 (a), Federal spending for health discounts in a fiscal
19 year shall be limited to the excess of—

20 (A) the amount specified in paragraph (2),
21 over

22 (B) the estimated Federal expenditures
23 under titles XVIII and XIX of the Social Secu-
24 rity Act (42 U.S.C. 1395 et seq.) for such year.

1 (2) SPECIFIED AMOUNT.—For purposes of
2 paragraph (1), the amount specified in this para-
3 graph for fiscal year—

4 (A) 1996, is \$282,800,000,000,

5 (B) 1997, is \$311,000,000,000,

6 (C) 1998, is \$343,100,000,000,

7 (D) 1999, is \$378,800,000,000,

8 (E) 2000, is \$416,300,000,000,

9 (F) 2001, is \$449,600,000,000,

10 (G) 2002, is \$481,100,000,000,

11 (H) 2003, is \$510,000,000,000,

12 (I) 2004, is \$540,600,000,000, and

13 (J) 2005 and any succeeding fiscal year, is

14 the specified amount under this paragraph for
15 the previous fiscal year increased by the per-
16 centage increase in the Gross Domestic Product
17 for the previous fiscal year.

18 (3) LOOK BACK PROCEDURE.—The Secretary
19 shall reduce (or increase) the amount specified in
20 paragraph (2) for any fiscal year (beginning with
21 1997) by the amount by which actual Federal ex-
22 penditures for titles XVIII and XIX of the Social
23 Security Act (42 U.S.C. 1395 et seq.) and Federal
24 spending for health discounts for the preceding year
25 are greater than (or less than) the amounts specified

1 in paragraph (2) for the preceding fiscal year (deter-
2 mined after the application of this paragraph).

3 (c) STATE SPENDING.—For purposes of subsection
4 (a)—

5 (1) MAINTENANCE OF EFFORT.—

6 (A) IN GENERAL.—For each calendar
7 quarter beginning after December 31, 1995, a
8 State shall make available for the health dis-
9 count program administered by the State under
10 this part an amount equal to one-quarter of the
11 annual maintenance of effort amount for the
12 State for the fiscal year in which such quarter
13 occurs as determined under subparagraph (B).

14 (B) ANNUAL STATE MAINTENANCE OF EF-
15 FORT AMOUNT.—

16 (i) IN GENERAL.—Except as provided
17 in subparagraph (C), the annual mainte-
18 nance of effort amount for any fiscal year
19 shall equal the base maintenance of effort
20 amount determined pursuant to clause (ii),
21 updated by the index in clause (iii) for
22 such fiscal year.

23 (ii) BASE AMOUNT.—For each State,
24 the base maintenance of effort amount
25 shall be the amount of total State expendi-

1 tures during fiscal year 1994 under title
2 XIX of the Social Security Act (42 U.S.C.
3 1396 et seq.) for acute care services.

4 (iii) INDEX.—

5 (I) IN GENERAL.—The Director
6 of the Office of Management and
7 Budget shall determine the index by
8 which the base amounts shall be up-
9 dated for each fiscal year after fiscal
10 year 1994 by determining the pro-
11 jected change from the preceding fis-
12 cal year in medicaid acute care spend-
13 ing (Federal and State) projected in
14 the baseline in effect at the time of
15 enactment of this Act.

16 (II) OUT YEARS.—For fiscal
17 years after the last fiscal year in the
18 baseline projections, the index shall
19 reflect overall change from the preced-
20 ing fiscal year in the Gross Domestic
21 Product.

22 (iv) ACUTE CARE SERVICES.—For
23 purposes of this subparagraph, the term
24 “acute care services” means all of the care
25 and services furnished under a State plan

1 under title XIX of the Social Security Act
2 (42 U.S.C. 1936 et seq.) except the follow-
3 ing:

4 (I) Nursing facility services (as
5 defined in section 1905(f) of the So-
6 cial Security Act (42 U.S.C.
7 1396d(f))).

8 (II) Intermediate care facility for
9 the mentally retarded services (as de-
10 fined in section 1905(d) of such Act
11 (42 U.S.C. 1396d(d))).

12 (III) Personal care services (as
13 described in section 1905(a)(24) of
14 such Act (42 U.S.C. 1396d(a)(24))).

15 (IV) Private duty nursing serv-
16 ices (as referred to in section
17 1905(a)(8) of such Act (42 U.S.C.
18 1396d(a)(8))).

19 (V) Home or community-based
20 services furnished under a waiver
21 granted under subsection (c), (d), or
22 (e) of section 1915 of such Act (42
23 U.S.C. 1396n).

24 (VI) Home and community care
25 furnished to functionally disabled el-

1 derly individuals under section 1929
2 of such Act (42 U.S.C. 1396t).

3 (VII) Community supported liv-
4 ing arrangements services under sec-
5 tion 1930 of such Act (42 U.S.C.
6 1396v).

7 (VIII) Case-management services
8 (as described in section 1915(g)(2) of
9 such Act (42 U.S.C. 1396n(g)(2))).

10 (IX) Home health care services
11 (as referred to in section 1905(a)(7)
12 of such Act (42 U.S.C. 1396d(a)(7))).

13 (X) Hospice care (as defined in
14 section 1905(o) of such Act (42
15 U.S.C. 1396d(o))).

16 (C) EXCEPTION.—For fiscal years begin-
17 ning in the first calendar year in which the an-
18 nual health discount entitlement is the maxi-
19 mum allowable (pursuant to subsection (d)), the
20 State maintenance of effort amount shall be the
21 amount for the preceding fiscal year increased
22 by the estimated overall growth in spending for
23 health discounts in the State as determined by
24 the Secretary.

1 (D) ADMINISTRATIVE EXPENSES.—A State
2 health discount program shall allocate a suffi-
3 cient portion of State maintenance of effort
4 spending to finance State expenses for admin-
5 istering the program.

6 (2) STATE MATCHING AMOUNTS.—For each cal-
7 endar quarter after December 31, 1995, each State
8 shall be required to pay 10 percent of the excess
9 of—

10 (A) the total costs of health discounts in a
11 State in such quarter, over

12 (B) the amount equal to—

13 (i) the State maintenance of effort
14 amount for such quarter, divided by

15 (ii) 1, minus the Federal medical as-
16 sistance percentage for the State under
17 title XIX of the Social Security Act (42
18 U.S.C. 1396 et seq.) for such fiscal year.

19 (3) OPTIONAL STATE SUPPLEMENTATION.—A
20 State, using State funds, may provide health dis-
21 counts in excess of the amount that eligible individ-
22 uals and eligible employees would otherwise be enti-
23 tled to pursuant to subsection (d) and to eligible in-
24 dividuals and eligible employees who would not oth-
25 erwise be entitled to such discounts.

1 (d) DETERMINING ENTITLEMENT TO HEALTH DIS-
2 COUNTS.—

3 (1) IN GENERAL.—At the beginning of each fis-
4 cal year, the Secretary shall establish the level of en-
5 titlement to health discounts for the upcoming cal-
6 endar year by setting—

7 (A) the maximum annual income allowed
8 for each category of eligibility under which eligi-
9 ble individuals and eligible employees are enti-
10 tled to health discounts, and

11 (B) the alternative benefits package used,
12 if necessary, for calculating the benchmarks
13 and health discounts for low income eligible in-
14 dividuals and low income eligible employees.

15 The Secretary shall set the level of entitlement for
16 a fiscal year so that the estimated total Federal
17 spending on health discounts does not exceed the
18 available Federal spending amount for such fiscal
19 year.

20 (2) STATE SPENDING.—In determining the an-
21 nual level of entitlement, the Secretary shall include
22 in the determination the State maintenance of effort
23 spending and State matching amounts but not op-
24 tional State supplementation.

25 (3) ORDER OF ENTITLEMENT.—

1 (A) POOR INDIVIDUALS AND EMPLOY-
2 EES.—

3 (i) IN GENERAL.—In any year, the
4 Secretary shall first ensure that all poor el-
5 igible individuals and poor eligible employ-
6 ees are entitled to health discounts based
7 on the nominal cost-sharing benefits pack-
8 age determined pursuant to section 113(b).

9 (ii) EXCESS SPENDING.—If the Sec-
10 retary determines that such a level of enti-
11 tlement would cause Federal spending to
12 exceed available amounts, the Secretary
13 shall reduce the maximum family adjusted
14 total income allowed for entitlement to
15 health discounts to such a level so as to
16 eliminate any estimated excess spending.

17 (B) OUT-OF-POCKET MAXIMUM FOR LOW
18 INCOME INDIVIDUALS AND EMPLOYEES.—

19 (i) IN GENERAL.—If, in any year, the
20 Secretary determines that all poor eligible
21 individuals and poor eligible employees
22 may be entitled to health discounts based
23 on the nominal cost-sharing benefits pack-
24 age, then the Secretary shall next ensure
25 that all low income eligible individuals and

1 low income eligible employees are entitled
2 to health discounts based on the alter-
3 native benefits package determined pursu-
4 ant to section 113(c).

5 (ii) EXCESS SPENDING.—If the Sec-
6 retary determines that providing entitle-
7 ment to health discounts for low income el-
8 igible individuals and low income eligible
9 employees based on the alternative benefits
10 package would (together with spending on
11 poor eligible individuals and poor eligible
12 employees under subparagraph (B)) cause
13 Federal spending to exceed available
14 amounts, the Secretary may only set the
15 maximum family adjusted total income al-
16 lowed for entitlement to health discounts
17 (based on the alternative benefits package)
18 for such low income individuals and em-
19 ployees at such a level so as to eliminate
20 any estimated excess spending.

21 (C) STANDARD BENEFITS PACKAGE FOR
22 LOW INCOME INDIVIDUALS AND EMPLOYEES.—

23 (i) IN GENERAL.—If the Secretary de-
24 termines that all eligible individuals and el-
25 igible employees described in subpara-

1 graphs (A)(i) and (B)(i) may be entitled to
2 health discounts, then the Secretary shall
3 ensure that low income eligible individuals
4 and low income eligible employees are enti-
5 tled to health discounts based on the
6 standard benefits package determined pur-
7 suant to section 113(a).

8 (ii) EXCESS SPENDING.—If the Sec-
9 retary determines that providing such a
10 level of entitlement would cause Federal
11 spending to exceed available amounts, the
12 Secretary shall increase the value of the al-
13 ternative benefits package above the value
14 provided under section 113(c) but below
15 the standard benefits package so as to
16 eliminate any estimated excess spending.

17 (4) EXCEPTION FOR MEDICAID-ELIGIBLES.—

18 For fiscal years 1996 through 2000, any individual
19 who—

20 (A) would have been eligible for medicaid
21 acute services based on eligibility standards on
22 the date of the enactment of this Act, and

23 (B) is otherwise an eligible individual or el-
24 igible employee,

1 shall be considered to be a poor eligible individual or
 2 poor eligible employee for purposes of paragraph
 3 (3)(A) and shall be entitled to health discounts
 4 based on the nominal cost-sharing benefits package
 5 without regard to the limit in available Federal
 6 spending and prior to the entitlement of other indi-
 7 viduals under such paragraph.

8 **PART II—TERMINATION OF AUTHORITY TO FUR-**
 9 **NISH ACUTE CARE SERVICES UNDER THE**
 10 **MEDICAID PROGRAM**

11 **SEC. 321. TERMINATION OF AUTHORITY TO FURNISH**
 12 **ACUTE CARE SERVICES UNDER THE MEDIC-**
 13 **AID PROGRAM.**

14 Title XIX of the Social Security Act (42 U.S.C. 1396
 15 et seq.) is amended by redesignating section 1931 as sec-
 16 tion 1932 and by inserting after section 1930 the following
 17 new section:

18 “TERMINATION OF AUTHORITY TO FURNISH ACUTE CARE
 19 SERVICES

20 “SEC. 1931. (a) IN GENERAL.—Except as provided
 21 in subsection (b), the authority provided by this title to
 22 furnish acute care services to any individual eligible for
 23 medical assistance under this title shall terminate on De-
 24 cember 31, 1994.

25 “(b) EXCEPTION FOR QUALIFIED MEDICARE BENE-
 26 FICIARIES.—

1 “(1) IN GENERAL.—Individuals entitled to ben-
2 efits under section 1905(p) shall remain entitled to
3 such benefits under State plans.

4 “(2) ADDITIONAL BENEFIT.—Each state plan
5 shall include as a mandatory benefit under section
6 1905(p)(3) the payment of premiums for qualified
7 medicare beneficiaries to medicare health plans as
8 provided in section 1876.

9 “(c) REPORT ON CONFORMING CHANGES.—By not
10 later than 90 days after the date of the enactment of the
11 Health Care Reform Act of 1994 the Secretary shall sub-
12 mit to Congress a report on changes in laws that should
13 be made in order to conform those laws to the termination
14 of authority under this section.

15 “(d) ACUTE CARE SERVICES.—The term ‘acute care
16 services’ means all of the care and services furnished
17 under a State plan under this title, except the following:

18 “(1) Nursing facility services (as defined in sec-
19 tion 1905(f)).

20 “(2) Intermediate care facility for the mentally
21 retarded services (as defined in section 1905(d)).

22 “(3) Personal care services (as described in sec-
23 tion 1905(a)(24)).

24 “(4) Private duty nursing services (as referred
25 to in section 1905(a)(8)).

1 “(5) Home or community-based services fur-
2 nished under a waiver granted under subsection (c),
3 (d), or (e) of section 1915).

4 “(6) Home and community care furnished to
5 functionally disabled elderly individuals under sec-
6 tion 1929.

7 “(7) Community supported living arrangements
8 services under section 1930.

9 “(8) Case-management services (as described in
10 section 1915(g)(2)).

11 “(9) Home health care services (as referred to
12 in section 1905(a)(7)).

13 “(10) Hospice care (as defined in section
14 1905(o)).”.

15 **Subtitle C—Increase in Tax on**
16 **Tobacco Products**

17 **SEC. 330. AMENDMENT OF 1986 CODE.**

18 Except as otherwise expressly provided, whenever in
19 this subtitle an amendment or repeal is expressed in terms
20 of an amendment to, or repeal of, a section or other provi-
21 sion, the reference shall be considered to be made to a
22 section or other provision of the Internal Revenue Code
23 of 1986.

1 **SEC. 331. INCREASE IN EXCISE TAXES ON TOBACCO PROD-**
2 **UCTS.**

3 (a) CIGARETTES.—Subsection (b) of section 5701 is
4 amended—

5 (1) by striking “\$12 per thousand (\$10 per
6 thousand on cigarettes removed during 1991 or
7 1992)” in paragraph (1) and inserting “\$30 per
8 thousand”, and

9 (2) by striking “\$25.20 per thousand (\$21 per
10 thousand on cigarettes removed during 1991 or
11 1992)” in paragraph (2) and inserting “\$63 per
12 thousand”.

13 (b) CIGARS.—Subsection (a) of section 5701 is
14 amended—

15 (1) by striking “\$1.125 cents per thousand
16 (93.75 cents per thousand on cigars removed during
17 1991 or 1992)” in paragraph (1) and inserting
18 “\$19.125 cents per thousand”, and

19 (2) by striking “equal to” and all that follows
20 in paragraph (2) and inserting “equal to 31.875 per-
21 cent of the price for which sold but not more than
22 \$75 per thousand.”

23 (c) CIGARETTE PAPERS.—Subsection (c) of section
24 5701 is amended by striking “0.75 cent (0.625 cent on
25 cigarette papers removed during 1991 or 1992)” and in-
26 serting “1.875 cents”.

1 (d) CIGARETTE TUBES.—Subsection (d) of section
2 5701 is amended by striking “1.5 cents (1.25 cents on
3 cigarette tubes removed during 1991 or 1992)” and in-
4 serting “3.75 cents”.

5 (e) SMOKELESS TOBACCO.—Subsection (e) of section
6 5701 is amended—

7 (1) by striking “36 cents (30 cents on snuff re-
8 moved during 1991 or 1992)” in paragraph (1) and
9 inserting “\$6.36”, and

10 (2) by striking “12 cents (10 cents on chewing
11 tobacco removed during 1991 or 1992)” in para-
12 graph (2) and inserting “\$6.12”.

13 (f) PIPE TOBACCO.—Subsection (f) of section 5701
14 is amended by striking “67.5 cents (56.25 cents on pipe
15 tobacco removed during 1991 or 1992)” and inserting
16 “\$6.675 cents”.

17 (g) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to articles removed (as defined in
19 section 5702(k) of the Internal Revenue Code of 1986,
20 as amended by this Act) after September 30, 1995.

21 (h) FLOOR STOCKS TAXES.—

22 (1) IMPOSITION OF TAX.—On tobacco products
23 and cigarette papers and tubes manufactured in or
24 imported into the United States which are removed
25 before October 1, 1995, and held on such date for

1 sale by any person, there is hereby imposed a tax in
2 an amount equal to the excess of—

3 (A) the tax which would be imposed under
4 section 5701 of the Internal Revenue Code of
5 1986 on the article if the article had been re-
6 moved on such date, over

7 (B) the prior tax (if any) imposed under
8 section 5701 or 7652 of such Code on such ar-
9 ticle.

10 (2) AUTHORITY TO EXEMPT CIGARETTES HELD
11 IN VENDING MACHINES.—To the extent provided in
12 regulations prescribed by the Secretary, no tax shall
13 be imposed by paragraph (1) on cigarettes held for
14 retail sale on October 1, 1995, by any person in any
15 vending machine. If the Secretary provides such a
16 benefit with respect to any person, the Secretary
17 may reduce the \$500 amount in paragraph (3) with
18 respect to such person.

19 (3) CREDIT AGAINST TAX.—Each person shall
20 be allowed as a credit against the taxes imposed by
21 paragraph (1) an amount equal to \$500. Such credit
22 shall not exceed the amount of taxes imposed by
23 paragraph (1) for which such person is liable.

24 (4) LIABILITY FOR TAX AND METHOD OF PAY-
25 MENT.—

1 (A) LIABILITY FOR TAX.—A person hold-
2 ing cigarettes on October 1, 1995, to which any
3 tax imposed by paragraph (1) applies shall be
4 liable for such tax.

5 (B) METHOD OF PAYMENT.—The tax im-
6 posed by paragraph (1) shall be paid in such
7 manner as the Secretary shall prescribe by reg-
8 ulations.

9 (C) TIME FOR PAYMENT.—The tax im-
10 posed by paragraph (1) shall be paid on or be-
11 fore December 31, 1995.

12 (5) ARTICLES IN FOREIGN TRADE ZONES.—
13 Notwithstanding the Act of June 18, 1934 (48 Stat.
14 998; 19 U.S.C. 81a) and any other provision of law,
15 any article which is located in a foreign trade zone
16 on October 1, 1995, shall be subject to the tax im-
17 posed by paragraph (1) if—

18 (A) internal revenue taxes have been deter-
19 mined, or customs duties liquidated, with re-
20 spect to such article before such date pursuant
21 to a request made under the 1st proviso of sec-
22 tion 3(a) of such Act, or

23 (B) such article is held on such date under
24 the supervision of a customs officer pursuant to
25 the 2d proviso of such section 3(a).

1 (6) DEFINITIONS.—For purposes of this sub-
2 section—

3 (A) IN GENERAL.—Terms used in this sub-
4 section which are also used in section 5702 of
5 the Internal Revenue Code of 1986 shall have
6 the respective meanings such terms have in
7 such section, and such term shall include arti-
8 cles first subject to the tax imposed by section
9 5701 of such Code by reason of the amend-
10 ments made by this Act.

11 (B) SECRETARY.—The term “Secretary”
12 means the Secretary of the Treasury.

13 (7) CONTROLLED GROUPS.—Rules similar to
14 the rules of section 5061(e)(3) of such Code shall
15 apply for purposes of this subsection.

16 (8) OTHER LAWS APPLICABLE.—All provisions
17 of law, including penalties, applicable with respect to
18 the taxes imposed by section 5701 of such Code
19 shall, insofar as applicable and not inconsistent with
20 the provisions of this subsection, apply to the floor
21 stocks taxes imposed by paragraph (1), to the same
22 extent as if such taxes were imposed by such section
23 5701. The Secretary may treat any person who bore
24 the ultimate burden of the tax imposed by para-

1 graph (1) as the person to whom a credit or refund
2 under such provisions may be allowed or made.

3 **SEC. 332. MODIFICATIONS OF CERTAIN TOBACCO TAX PRO-**
4 **VISIONS.**

5 (a) EXEMPTION FOR EXPORTED TOBACCO PROD-
6 UCTS AND CIGARETTE PAPERS AND TUBES TO APPLY
7 ONLY TO ARTICLES MARKED FOR EXPORT.—

8 (1) Subsection (b) of section 5704 is amended
9 by adding at the end the following new sentence:
10 “Tobacco products and cigarette papers and tubes
11 may not be transferred or removed under this sub-
12 section unless such products or papers and tubes
13 bear such marks, labels, or notices as the Secretary
14 shall by regulations prescribe.”.

15 (2) Section 5761 is amended by redesignating
16 subsections (c) and (d) as subsections (d) and (e),
17 respectively, and by inserting after subsection (b)
18 the following new subsection:

19 “(c) SALE OF TOBACCO PRODUCTS AND CIGARETTE
20 PAPERS AND TUBES FOR EXPORT.—Except as provided
21 in subsections (b) and (d) of section 5704—

22 “(1) every person who sells, relands, or receives
23 within the jurisdiction of the United States any to-
24 bacco products or cigarette papers or tubes which

1 have been labeled or shipped for exportation under
2 this chapter,

3 “(2) every person who sells or receives such
4 relanded tobacco products or cigarette papers or
5 tubes, and

6 “(3) every person who aids or abets in such
7 selling, relanding, or receiving,

8 shall, in addition to the tax and any other penalty provided
9 in this title, be liable for a penalty equal to the greater
10 of \$1,000 or 5 times the amount of the tax imposed by
11 this chapter. All tobacco products and cigarette papers
12 and tubes relanded within the jurisdiction of the United
13 States, and all vessels, vehicles, and aircraft used in such
14 relanding or in removing such products, papers, and tubes
15 from the place where relanded, shall be forfeited to the
16 United States.”.

17 (3) Subsection (a) of section 5761 is amended
18 by striking “subsection (b)” and inserting “sub-
19 section (b) or (c)”.

20 (4) Subsection (d) of section 5761, as redesign-
21 nated by paragraph (2), is amended by striking
22 “The penalty imposed by subsection (b)” and insert-
23 ing “The penalties imposed by subsections (b) and
24 (c)”.

1 (5)(A) Subpart F of chapter 52 is amended by
 2 adding at the end the following new section:

3 **“SEC. 5754. RESTRICTION ON IMPORTATION OF PRE-**
 4 **VIOUSLY EXPORTED TOBACCO PRODUCTS.**

5 “(a) IN GENERAL.—Tobacco products and cigarette
 6 papers and tubes previously exported from the United
 7 States may be imported or brought into the United States
 8 only as provided in section 5704(d).

9 “(b) CROSS REFERENCE.—

“For penalty for the sale of cigarettes in the United States which are labeled for export, see section 5761(d).”.

10 (B) The table of sections for subpart F of chap-
 11 ter 52 of such Code is amended by adding at the
 12 end the following new item:

“Sec. 5754. Restriction on importation of previously exported tobacco products.”.

13 (b) IMPORTERS REQUIRED TO BE QUALIFIED.—

14 (1) Sections 5712, 5713(a), 5721, 5722,
 15 5762(a)(1), 5763(b) and 5763(c) are each amended
 16 by inserting “or importer” after “manufacturer”.

17 (2) The heading of subsection (b) of section
 18 5763 is amended by inserting “QUALIFIED IMPORT-
 19 ERS,” after “MANUFACTURERS,”.

20 (3) The heading for subchapter B of chapter 52
 21 is amended by inserting “**and Importers**” after
 22 “**Manufacturers**”.

1 (4) The item relating to subchapter B in the
2 table of subchapters for chapter 52 is amended by
3 inserting “and importers” after “manufacturers”.

4 (c) REPEAL OF TAX-EXEMPT SALES TO EMPLOYEES
5 OF CIGARETTE MANUFACTURERS.—

6 (1) Subsection (a) of section 5704 is amend-
7 ed—

8 (A) by striking “EMPLOYEE USE OR” in
9 the heading, and

10 (B) by striking “for use or consumption by
11 employees or” in the text.

12 (2) Subsection (e) of section 5723 is amended
13 by striking “for use or consumption by their employ-
14 ees, or for experimental purposes” and inserting
15 “for experimental purposes”.

16 (d) REPEAL OF TAX-EXEMPT SALES TO UNITED
17 STATES.—Subsection (b) of section 5704 is amended by
18 striking “and manufacturers may similarly remove such
19 articles for use of the United States;”.

20 (e) BOOKS OF 25 OR FEWER CIGARETTE PAPERS
21 SUBJECT TO TAX.—Subsection (c) of section 5701 is
22 amended by striking “On each book or set of cigarette
23 papers containing more than 25 papers,” and inserting
24 “On cigarette papers,”.

1 (f) STORAGE OF TOBACCO PRODUCTS.—Subsection
 2 (k) of section 5702 is amended by inserting “under section
 3 5704” after “internal revenue bond”.

4 (g) AUTHORITY TO PRESCRIBE MINIMUM MANUFAC-
 5 TURING ACTIVITY REQUIREMENTS.—Section 5712 is
 6 amended by striking “or” at the end of paragraph (1),
 7 by redesignating paragraph (2) as paragraph (3), and by
 8 inserting after paragraph (1) the following new paragraph:

9 “(2) the activity proposed to be carried out at
 10 such premises does not meet such minimum capacity
 11 or activity requirements as the Secretary may pre-
 12 scribe, or”.

13 (h) EFFECTIVE DATE.—The amendments made by
 14 this section shall apply to articles removed (as defined in
 15 section 5702(k) of the Internal Revenue Code of 1986,
 16 as amended by this Act) after September 30, 1995.

17 **SEC. 333. IMPOSITION OF EXCISE TAX ON MANUFACTURE**
 18 **OR IMPORTATION OF ROLL-YOUR-OWN TO-**
 19 **BACCO.**

20 (a) IN GENERAL.—Section 5701 (relating to rate of
 21 tax) is amended by redesignating subsection (g) as sub-
 22 section (h) and by inserting after subsection (f) the follow-
 23 ing new subsection:

24 “(g) ROLL-YOUR-OWN TOBACCO.—On roll-your-own
 25 tobacco, manufactured in or imported into the United

1 States, there shall be imposed a tax of \$6 per pound (and
 2 a proportionate tax at the like rate on all fractional parts
 3 of a pound).”.

4 (b) ROLL-YOUR-OWN TOBACCO.—Section 5702 (re-
 5 lating to definitions) is amended by adding at the end the
 6 following new subsection:

7 “(p) ROLL-YOUR-OWN TOBACCO.—The term ‘roll-
 8 your-own tobacco’ means any tobacco which, because of
 9 its appearance, type, packaging, or labeling, is suitable for
 10 use and likely to be offered to, or purchased by, consumers
 11 as tobacco for making cigarettes.”.

12 (c) TECHNICAL AMENDMENTS.—

13 (1) Subsection (c) of section 5702 is amended
 14 by striking “and pipe tobacco” and inserting “pipe
 15 tobacco, and roll-your-own tobacco”.

16 (2) Subsection (d) of section 5702 is amend-
 17 ed—

18 (A) in the material preceding paragraph
 19 (1), by striking “or pipe tobacco” and inserting
 20 “pipe tobacco, or roll-your-own tobacco”, and

21 (B) by striking paragraph (1) and insert-
 22 ing the following new paragraph:

23 “(1) a person who produces cigars, cigarettes,
 24 smokeless tobacco, pipe tobacco, or roll-your-own to-

1 bacco solely for his own personal consumption or
2 use, and”.

3 (3) The chapter heading for chapter 52 is
4 amended to read as follows:

5 **“CHAPTER 52—TOBACCO PRODUCTS AND**
6 **CIGARETTE PAPERS AND TUBES”.**

7 (4) The table of chapters for subtitle E is
8 amended by striking the item relating to chapter 52
9 and inserting the following new item:

 “CHAPTER 52. Tobacco products and cigarette papers and
 tubes.”.

10 (d) EFFECTIVE DATE.—

11 (1) IN GENERAL.—The amendments made by
12 this section shall apply to roll-your-own tobacco re-
13 moved (as defined in section 5702(k) of the Internal
14 Revenue Code of 1986, as amended by this Act)
15 after September 30, 1995.

16 (2) TRANSITIONAL RULE.—Any person who—

17 (A) on the date of the enactment of this
18 Act is engaged in business as a manufacturer of
19 roll-your-own tobacco or as an importer of to-
20 bacco products or cigarette papers and tubes,
21 and

22 (B) before October 1, 1995, submits an
23 application under subchapter B of chapter 52
24 of such Code to engage in such business,

1 may, notwithstanding such subchapter B, continue
 2 to engage in such business pending final action on
 3 such application. Pending such final action, all pro-
 4 visions of such chapter 52 shall apply to such appli-
 5 cant in the same manner and to the same extent as
 6 if such applicant were a holder of a permit under
 7 such chapter 52 to engage in such business.

8 **TITLE IV—IMPROVING ACCESS**
 9 **IN RURAL AREAS**

10 **SEC. 401. COMMUNITY HEALTH CENTERS.**

11 Section 330(g)(1)(A) of the Public Health Service
 12 Act (42 U.S.C. 254c(g)(1)(A)) is amended by striking
 13 “and such sums” and inserting “such sums” and by in-
 14 serting before the period the following: “, \$800,000,000
 15 for fiscal year 1995, \$960,000,000 for fiscal year 1996,
 16 \$1,100,000,000 for fiscal year 1997, and \$1,200,000,000
 17 for fiscal year 1998”.

18 **SEC. 402. NATIONAL HEALTH SERVICE CORPS.**

19 Section 338H(b)(1) of the Public Health Act (42
 20 U.S.C. 254q(b)(1)) is amended by striking “and such
 21 sums” and inserting “such sums” and by inserting before
 22 the period the following: “, \$96,000,000 for fiscal year
 23 1995, \$115,000,000 for fiscal year 1996, \$138,000,000
 24 for fiscal year 1997, and \$160,000,000 for fiscal year
 25 1998”.

1 **SEC. 403. TAX INCENTIVES FOR PRACTICE IN FRONTIER,**
2 **RURAL, AND URBAN UNDERSERVED AREAS.**

3 (a) REFUNDABLE CREDIT FOR CERTAIN PRIMARY
4 HEALTH SERVICES PROVIDERS.—

5 (1) IN GENERAL.—Subpart C of part IV of sub-
6 chapter A of chapter 1 of the Internal Revenue Code
7 of 1986 (relating to refundable credits) is amended
8 by inserting after section 34 the following new sec-
9 tion:

10 **“SEC. 34A. PRIMARY HEALTH SERVICES PROVIDERS.**

11 “(a) ALLOWANCE OF CREDIT.—In the case of a
12 qualified primary health services provider, there is allowed
13 as a credit against the tax imposed by this subtitle for
14 any taxable year in a mandatory service period an amount
15 equal to the product of—

16 “(1) the lesser of—

17 “(A) the number of months of such period
18 occurring in such taxable year, or

19 “(B) 36 months, reduced by the number of
20 months taken into account under this para-
21 graph with respect to such provider for all pre-
22 ceding taxable years (whether or not in the
23 same mandatory service period), multiplied by

24 “(2) \$1,000 (\$500 in the case of a qualified
25 primary health services provider who is a physician
26 assistant or a nurse practitioner).

1 “(b) QUALIFIED PRIMARY HEALTH SERVICES PRO-
 2 VIDER.—For purposes of this section, the term ‘qualified
 3 primary health services provider’ means any physician,
 4 physician assistant, or nurse practitioner who for any
 5 month during a mandatory service period is certified by
 6 the Bureau to be a primary health services provider who—

7 “(1) is providing primary health services—

8 “(A) full-time, and

9 “(B) to individuals at least 80 percent of
 10 whom reside in a health professional shortage
 11 area (as defined in subsection (d)(2)),

12 “(2) is not receiving during such year a scholar-
 13 ship under the National Health Service Corps Schol-
 14 arship Program or a loan repayment under the Na-
 15 tional Health Service Corps Loan Repayment Pro-
 16 gram,

17 “(3) is not fulfilling service obligations under
 18 such Programs, and

19 “(4) has not defaulted on such obligations.

20 “(c) MANDATORY SERVICE PERIOD.—For purposes
 21 of this section, the term ‘mandatory service period’ means
 22 the period of 60 consecutive calendar months beginning
 23 with the first month the taxpayer is a qualified primary
 24 health services provider.

1 “(d) DEFINITIONS AND SPECIAL RULES.—For pur-
2 poses of this section—

3 “(1) BUREAU.—The term ‘Bureau’ means the
4 Bureau of Health Care Delivery and Assistance,
5 Health Resources and Services Administration of the
6 United States Public Health Service.

7 “(2) HEALTH PROFESSIONAL SHORTAGE
8 AREA.—The term ‘health professional shortage area’
9 means—

10 “(A) a geographic area in which there are
11 6 or fewer individuals residing per square mile,

12 “(B) a health professional shortage area
13 (as defined in section 332(a)(1)(A) of the Pub-
14 lic Health Service Act),

15 “(C) an area which is determined by the
16 Secretary of Health and Human Services as
17 equivalent to an area described in subparagraph
18 (A) and which is designated by the Bureau of
19 the Census as not urbanized, or

20 “(D) a community that is certified as un-
21 derserved by the Secretary for purposes of par-
22 ticipation in the rural health clinic program
23 under title XVIII of the Social Security Act.

1 “(3) PHYSICIAN.—The term ‘physician’ has the
2 meaning given to such term by section 1861(r) or
3 the Social Security Act.

4 “(4) PHYSICIAN ASSISTANT; NURSE PRACTI-
5 TIONER.—The terms ‘physician assistant’ and ‘nurse
6 practitioner’ have the meanings given to such terms
7 by section 1861(aa)(5) of the Social Security Act.

8 “(5) PRIMARY HEALTH SERVICES PROVIDER.—
9 The term ‘primary health services provider’ means a
10 provider of primary health services (as defined in
11 section 330(b)(1) of the Public Health Service Act).

12 “(e) RECAPTURE OF CREDIT.—

13 “(1) IN GENERAL.—If, during any taxable year,
14 there is a recapture event, then the tax of the tax-
15 payer under this chapter for such taxable year shall
16 be increased by an amount equal to the product of—

17 “(A) the applicable percentage, and

18 “(B) the aggregate unrecaptured credits
19 allowed to such taxpayer under this section for
20 all prior taxable years.

21 “(2) APPLICABLE RECAPTURE PERCENTAGE.—

22 “(A) IN GENERAL.—For purposes of this
23 subsection, the applicable recapture percentage
24 shall be determined from the following table:

“If the recapture event occurs during:	The applicable recapture percentage is:
Months 1–24	100
Months 25–36	75
Months 37–48	50
Months 49–60	25
Months 61 and thereafter	0.

1 “(B) TIMING.—For purposes of subpara-
2 graph (A), month 1 shall begin on the first day
3 of the mandatory service period.

4 “(3) RECAPTURE EVENT DEFINED.—

5 “(A) IN GENERAL.—For purposes of this
6 subsection, the term ‘recapture event’ means
7 the failure of the taxpayer to be a qualified pri-
8 mary health services provider for any month
9 during any mandatory service period.

10 “(B) CESSATION OF DESIGNATION.—The
11 cessation of the designation of any area as a
12 rural health professional shortage area after the
13 beginning of the mandatory service period for
14 any taxpayer shall not constitute a recapture
15 event.

16 “(C) SECRETARIAL WAIVER.—The Sec-
17 retary may waive any recapture event caused by
18 extraordinary circumstances.

19 “(4) NO CREDITS AGAINST TAX.—Any increase
20 in tax under this subsection shall not be treated as
21 a tax imposed by this chapter for purposes of deter-

1 mining the amount of any credit under subpart A,
 2 B, or D of this part.”.

3 (2) CLERICAL AMENDMENT.—The table of sec-
 4 tions for subpart C of part IV of subchapter A of
 5 chapter 1 of such Code is amended by inserting
 6 after the item relating to section 34 the following
 7 new item:

“Sec. 34A. Primary health services providers.”.

8 (3) EFFECTIVE DATE.—The amendments made
 9 by this subsection shall apply to taxable years begin-
 10 ning after the date of the enactment of this Act.

11 (b) NATIONAL HEALTH SERVICE CORPS LOAN RE-
 12 PAYMENTS EXCLUDED FROM GROSS INCOME.—

13 (1) IN GENERAL.—Part III of subchapter B of
 14 chapter 1 of the Internal Revenue Code of 1986 (re-
 15 lating to items specifically excluded from gross in-
 16 come) is amended by redesignating section 137 as
 17 section 138 and by inserting after section 136 the
 18 following new section:

19 **“SEC. 137. NATIONAL HEALTH SERVICE CORPS LOAN RE-**
 20 **PAYMENTS.**

21 “(a) GENERAL RULE.—Gross income shall not in-
 22 clude any qualified loan repayment.

23 “(b) QUALIFIED LOAN REPAYMENT.—For purposes
 24 of this section, the term ‘qualified loan repayment’ means
 25 any payment made on behalf of the taxpayer by the Na-

1 tional Health Service Corps Loan Repayment Program
2 under section 338B(g) of the Public Health Service Act.”.

3 (2) CONFORMING AMENDMENT.—Paragraph (3)
4 of section 338B(g) of the Public Health Service Act
5 (42 U.S.C. 254l–1(g)) is amended by striking “Fed-
6 eral, State, or local” and inserting “State or local”.

7 (3) CLERICAL AMENDMENT.—The table of sec-
8 tions for part III of subchapter B of chapter 1 of
9 the Internal Revenue Code of 1986 is amended by
10 striking the item relating to section 136 and insert-
11 ing the following:

“Sec. 137. National Health Service Corps loan repayments.
“Sec. 138. Cross references to other Acts.”.

12 (4) EFFECTIVE DATE.—The amendments made
13 by this subsection shall apply to payments made
14 under section 338B(g) of the Public Health Service
15 Act (42 U.S.C. 254l–1(g)) after the date of the en-
16 actment of this Act.

17 **SEC. 404. INCENTIVES FOR PRIMARY CARE RESIDENTS.**

18 (a) IN GENERAL.—Section 1886(h) of the Social Se-
19 curity Act (42 U.S.C. 1395 ww(h)) is amended—

20 (1) by striking paragraph (2) and inserting the
21 following new paragraph:

22 “(2) DETERMINATION OF APPROVED FTE RESI-
23 DENT AMOUNTS.—The Secretary shall determine an
24 approved FTE resident amount for each cost report-

1 ing period beginning after October 1, 1994, as fol-
2 lows:

3 “(A) DETERMINING NATIONAL AVERAGE
4 SALARY PER FTE RESIDENT IN FISCAL YEAR
5 1992.—The Secretary shall determine the na-
6 tional average salary for fiscal year 1992 for a
7 full-time-equivalent resident in an approved
8 medical residency training program.

9 “(B) UPDATING TO A COST REPORTING
10 PERIOD THAT BEGINS IN FISCAL YEAR 1995.—
11 The Secretary shall update the amount deter-
12 mined under subparagraph (A) by the esti-
13 mated percentage change in the Consumer
14 Price Index from the midpoint of fiscal year
15 1992 to the midpoint of each cost reporting pe-
16 riod that begins in fiscal year 1995.

17 “(C) UPDATING TO SUBSEQUENT COST RE-
18 PORTING PERIODS.—For each subsequent cost
19 reporting period, the Secretary shall update the
20 amount determined under subparagraph (B) or
21 this subparagraph for an immediately preceding
22 cost reporting period by the estimated percent-
23 age change in the Consumer Price Index from
24 the midpoint of that preceding period to the
25 midpoint of that subsequent period, with appro-

1 priate adjustments to reflect previous under- or
2 over-estimations in the estimated percentage
3 change in that index.”,

4 (2) in paragraph (3)(B)(i), by striking “hos-
5 pital’s”, and

6 (3) in paragraph (4), by striking subparagraph
7 (C) and inserting the following new subparagraph:

8 “(C) WEIGHTING FACTOR FOR CERTAIN
9 RESIDENTS.—Subject to subparagraph (D),
10 such rules shall provide, in calculating the num-
11 ber of full-time-equivalent residents in an ap-
12 proved residency program—

13 “(i) that the weighting factor for a
14 primary care (as defined by the Secretary)
15 resident, or for an intern, is 2.2;

16 “(ii) that the weighting factor for a
17 nonprimary care resident who is in the
18 resident’s initial residency period is 2.0;
19 and

20 “(iii) that the weighting factor for a
21 nonprimary care resident who is not in the
22 resident’s initial residency period is 1.2.

23 The Secretary shall make such adjustments as
24 are necessary to the weighting factors to main-
25 tain aggregate payments under this section to

1 all hospitals at the same level that such pay-
2 ments would have been made under this section
3 prior to enactment of the amendments made to
4 this section by the Health Care Reform Act of
5 1994.”.

6 (b) EFFECTIVE DATES.—

7 (1) IN GENERAL.—Except as otherwise pro-
8 vided by paragraph (2), the amendments made by
9 this section shall apply to cost reporting periods be-
10 ginning after October 1, 1994.

11 (2) SPECIAL RULE.—For a cost reporting pe-
12 riod that falls partly in fiscal year 1994 and partly
13 in fiscal year 1995, the provisions of section
14 1886(h), as in effect before the date of enactment of
15 this Act, shall apply proportionally to that part of
16 the cost reporting period that occurs before fiscal
17 year 1995.

18 **TITLE V—OTHER HEALTH CARE**
19 **COST REDUCTION MEASURES**
20 **Subtitle A—Medical Liability**
21 **Reform**

22 **SEC. 501. FEDERAL STANDARDS FOR STATE-BASED MEDI-**
23 **CAL LIABILITY REFORM.**

24 (a) IN GENERAL.—The Secretary, in consultation
25 with the Attorney General, shall develop and publish medi-

1 cal liability reform standards in accordance with this sub-
2 title that States must meet in order to be certified under
3 section 502.

4 (b) BINDING ALTERNATIVE DISPUTE RESOLU-
5 TION.—

6 (1) REQUIREMENTS.—The standards developed
7 under subsection (a) shall require that a State—

8 (A) require all claims of medical injury
9 arising in such State be resolved under binding
10 dispute resolution systems that—

11 (i) provide timely and impartial deci-
12 sions of liability and damage awards,

13 (ii) make determinations of liability
14 and damage awards based on the best sci-
15 entific learning and judgment of objective
16 experts,

17 (iii) provide data and standardized in-
18 formation regarding evidence of medical in-
19 juries and the causes of such injuries to
20 Federal and State agencies responsible for
21 monitoring or disciplining health care pro-
22 viders, and

23 (iv) do not employ lay juries or simi-
24 larly constituted lay decisionmaking bodies
25 to make such determinations;

1 (B) require that the decisions made
2 through the binding dispute resolution system
3 be final and not subject to further review by
4 any court, except that a party to a dispute may
5 obtain review of such decision in any court of
6 competent jurisdiction in the State wherein the
7 decision was made if—

8 (i) the award under such decision was
9 procured by corruption, fraud, or other
10 undue means,

11 (ii) there was evident partiality or cor-
12 ruption on the part of the arbiter,

13 (iii) the arbiter was guilty of mis-
14 conduct in refusing to postpone the hear-
15 ing, upon sufficient cause shown, or in re-
16 fusing to hear evidence pertinent and ma-
17 terial to the controversy, or of any mis-
18 behavior by which the rights of any party
19 were prejudiced, or

20 (iv) the arbiter exceeded its powers or
21 so imperfectly executed them that a final
22 and definite award upon the claim was not
23 made; and

24 (C) require that where an arbiters award is
25 vacated pursuant to State provisions established

1 under subparagraph (B) that the court direct
2 that the matter be reheard by another arbiter
3 under the procedures prescribed by the State
4 dispute resolution system.

5 (2) OPTIONS.—The standards developed under
6 subsection (a) shall permit a State to—

7 (A) allow private entities to provide all or
8 some of the dispute resolution services required
9 by the State dispute resolution system, and

10 (B) allow alternative methods for deter-
11 mining liability and compensation for personal
12 injuries other than provider negligence and as-
13 sessments of damage awards.

14 (3) BINDING ARBITRATION.—In the standards
15 developed under subsection (a), the Secretary shall
16 outline a standard arbitration process that States
17 could adopt to meet Federal criteria (so long as
18 other elements of the State system meet the require-
19 ments of this section) and that includes the follow-
20 ing:

21 (A) Decisionmaking by a 3-person arbitra-
22 tion panel with expertise in medical injury dis-
23 putes chosen from a roster of qualified and
24 independent arbitrators.

1 (B) A period to permit the discovery of evi-
2 dence.

3 (C) The right to a hearing.

4 (D) The right to a decision not later than
5 6 months after the date on which the claim was
6 filed.

7 (E) The right to a written decision.

8 (c) DAMAGES.—When a claim that is subject to reso-
9 lution in accordance with State systems established under
10 the standards developed under subsection (a) results in a
11 finding of liability, States shall require that the damages
12 awarded adhere to the following requirements:

13 (1) Awards for noneconomic damages shall not
14 exceed \$250,000.

15 (2) Awards shall be reduced for any collateral
16 source payments to which the patient is entitled for
17 the medical injury for which the claim was filed.

18 (3) In the case of an award in excess of
19 \$100,000, claimants shall accept periodic payment
20 of the amount of such awards that are intended to
21 compensate the claimant for damages expected to be
22 incurred in the future such as lost income and medi-
23 cal expenses.

24 (4) An award of punitive damages shall not be
25 paid to the claimant, but shall be paid to the State

1 if the State has submitted a plan to the Secretary,
2 and the Secretary has certified such a plan as part
3 of certifying the State medical liability reform in ac-
4 cordance with section 502, to use such funds to im-
5 prove the monitoring, disciplining, and educating of
6 health care providers in the State to ensure they
7 meet standards of competency.

8 (d) ACCOUNTABLE HEALTH PLANS.—

9 (1) IN GENERAL.—To be approved by the appli-
10 cable regulatory authority as an AHP under section
11 112, a health plan shall clearly identify for the pur-
12 chasers of the plan the individuals or entity that will
13 be responsible for any findings of liability for claims
14 of medical injury.

15 (2) ENFORCEMENT OF CONTRACTS.—A State
16 shall ensure that provisions in AHP contracts that—

17 (A) cite medical practice guidelines, cer-
18 tified pursuant to section 502, and which shall
19 be followed in rendering services, shall be
20 deemed to supply the standard of care to be
21 employed in determining liability under the
22 State dispute resolution system, and

23 (B) establish particular rules governing the
24 resolution of medical injury claims, consistent
25 with the State dispute resolution system, are re-

1 quired elements for resolving any claims of
2 medical injury for care provided in accordance
3 with the AHP.

4 **SEC. 502. CERTIFICATION.**

5 (a) STATE REFORMS.—Not later than 12 months
6 after the date of enactment of this Act, the Secretary, in
7 consultation with the Attorney General, shall promulgate
8 regulations that establish the criteria and procedures by
9 which the Secretary (or individuals to whom the Secretary
10 has delegated such authority) will determine whether or
11 not a State has met the standards established under sec-
12 tion 501(a) and any other standards determined necessary
13 by the Secretary.

14 (b) STANDARDS FOR IMPOSING LIABILITY.—Not
15 later than 12 months after the date of enactment of this
16 Act, the Secretary shall promulgate regulations that estab-
17 lish the criteria to be used for the certification of medical
18 practice guidelines by the Secretary (or individuals to
19 whom the Secretary has delegated such authority), includ-
20 ing criteria to ensure that such guidelines—

- 21 (1) reflect up-to-date scientific learning and the
22 judgment of objective experts,
23 (2) are supported by proper documentation, and
24 (3) are accompanied by justifications for the
25 standards established.

1 (c) OTHER REGULATIONS.—Not later than 12
 2 months after the date of enactment of this Act, the Sec-
 3 retary of Health and Human Services shall promulgate
 4 other regulations necessary to carry out this Act.

5 **SEC. 503. RELATION TO OTHER LAWS.**

6 The procedures required under this Act for fairly and
 7 quickly resolving claims against health care providers for
 8 personal injury shall be exclusive, and no action seeking
 9 recovery for any personal injury covered by this Act shall
 10 be permitted in any Federal or State court except as ex-
 11 pressly provided herein.

12 **Subtitle B—Antitrust Provisions**

13 **SEC. 511. PUBLICATION OF GUIDELINES FOR ACCOUNT-**
 14 **ABLE HEALTH PLANS.**

15 (a) IN GENERAL.—The President shall provide for
 16 the development and publication of explicit guidelines on
 17 the application of antitrust laws to AHPs. The guidelines
 18 shall be designed to facilitate AHP development and oper-
 19 ation, consistent with the antitrust laws.

20 (b) REVIEW PROCESS.—The Attorney General shall
 21 establish a review process under which an AHP (or organi-
 22 zation that proposes to establish an AHP) may obtain a
 23 prompt opinion from the Department of Justice on the
 24 AHP's conformity with the antitrust laws. If the Depart-
 25 ment of Justice determines that an AHP conforms with

1 the antitrust laws, the AHP shall not be liable under such
2 laws regarding the development and operation of the
3 AHP, as reviewed by the Department.

4 (c) ANTITRUST LAWS DEFINED.—In this section, the
5 term “antitrust laws” has the meaning given such term
6 in subsection (a) of the first section of the Clayton Act
7 (15 U.S.C. 12(a)), except that such term includes section
8 5 of the Federal Trade Commission Act (15 U.S.C. 45)
9 to the extent such section applies to unfair methods of
10 competition.

11 **SEC. 512. ISSUANCE OF HEALTH CARE CERTIFICATES OF**
12 **PUBLIC ADVANTAGE.**

13 (a) ISSUANCE AND EFFECT OF CERTIFICATE.—The
14 Attorney General, after consultation with the Secretary,
15 shall issue in accordance with this section a certificate of
16 public advantage to each eligible health care collaborative
17 effort that complies with the requirements in effect under
18 this section on or after the expiration of the 1-year period
19 that begins on the date of the enactment of this Act (with-
20 out regard to whether or not the Attorney General has
21 promulgated regulations to carry out this section by such
22 date). Such collaborative effort, and the parties to such
23 effort, shall not be liable under any of the antitrust laws
24 for conduct described in such certificate and engaged in

1 by such effort if such conduct occurs while such certificate
2 is in effect.

3 (b) REQUIREMENTS APPLICABLE TO ISSUANCE OF
4 CERTIFICATES.—

5 (1) STANDARDS TO BE MET.—The Attorney
6 General shall issue a certificate to an eligible health
7 care collaborative effort if the Attorney General
8 finds that—

9 (A) the benefits that are likely to result
10 from carrying out the effort outweigh the re-
11 duction in competition (if any) that is likely to
12 result from the effort, and

13 (B) such reduction in competition is rea-
14 sonably necessary to obtain such benefits.

15 (2) FACTORS TO BE CONSIDERED.—

16 (A) WEIGHING OF BENEFITS AGAINST RE-
17 Duction IN COMPETITION.—For purposes of
18 making the finding described in paragraph
19 (1)(A), the Attorney General shall consider
20 whether the collaborative effort is likely—

21 (i) to maintain or to increase the
22 quality of health care,

23 (ii) to increase access to health care,

24 (iii) to achieve cost efficiencies that
25 will be passed on to health care consumers,

1 such as economies of scale, reduced trans-
2 action costs, and reduced administrative
3 costs,

4 (iv) to preserve the operation of
5 health care facilities located in underserved
6 geographical areas,

7 (v) to improve utilization of health
8 care resources, and

9 (vi) to reduce inefficient health care
10 resource duplication.

11 (B) NECESSITY OF REDUCTION IN COM-
12 PETITION.—For purposes of making the finding
13 described in paragraph (1)(B), the Attorney
14 General shall consider—

15 (i) the ability of the providers of
16 health care services that are (or are likely
17 to be) affected by the health care collabo-
18 rative effort and the entities responsible
19 for making payments to such providers to
20 negotiate societally optimal payment and
21 service arrangements,

22 (ii) the effects of the health care col-
23 laborative effort on premiums and other
24 charges imposed by the entities described
25 in clause (i), and

1 (iii) the availability of equally effi-
2 cient, less restrictive alternatives to achieve
3 the benefits that are intended to be
4 achieved by carrying out the effort.

5 (c) ESTABLISHMENT OF CRITERIA AND PROCE-
6 DURES.—Subject to subsections (d) and (e), not later than
7 1 year after the date of the enactment of this Act, the
8 Attorney General and the Secretary shall establish jointly
9 by rule the criteria and procedures applicable to the issu-
10 ance of certificates under subsection (a). The rules shall
11 specify the form and content of the application to be sub-
12 mitted to the Attorney General to request a certificate,
13 the information required to be submitted in support of
14 such application, the procedures applicable to denying and
15 to revoking a certificate, and the procedures applicable to
16 the administrative appeal (if such appeal is authorized by
17 rule) of the denial and the revocation of a certificate. Such
18 information may include the terms of the health care col-
19 laborative effort (in the case of an effort in existence as
20 of the time of the application) and implementation plan
21 for the collaborative effort.

22 (d) ELIGIBLE HEALTH CARE COLLABORATIVE EF-
23 FORT.—To be an eligible health care collaborative effort
24 for purposes of this section, a health care collaborative ef-
25 fort shall submit to the Attorney General an application

1 that complies with the rules in effect under subsection (c)
2 and that includes—

3 (1) an agreement by the parties to the effort
4 that the effort will not foreclose competition by en-
5 tering into contracts that prevent health care provid-
6 ers from providing health care in competition with
7 the effort,

8 (2) an agreement that the effort will submit to
9 the Attorney General annually a report that de-
10 scribes the operations of the effort and information
11 regarding the impact of the effort on health care
12 and on competition in health care, and

13 (3) an agreement that the parties to the effort
14 will notify the Attorney General and the Secretary of
15 the termination of the effort not later than 30 days
16 after such termination occurs.

17 (e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—
18 Not later than 30 days after an eligible health care col-
19 laborative effort submits to the Attorney General an appli-
20 cation that complies with the rules in effect under sub-
21 section (c) and with subsection (d), the Attorney General
22 shall issue or deny the issuance of such certificate. If, be-
23 fore the expiration of such 30-day period, the Attorney
24 General fails to issue or deny the issuance of such certifi-

1 cate, the Attorney General shall be deemed to have issued
2 such certificate.

3 (f) REVOCATION OF CERTIFICATE.—Whenever the
4 Attorney General finds that a health care collaborative ef-
5 fort with respect to which a certificate is in effect does
6 not meet the standards specified in subsection (b), the At-
7 torney General shall revoke such certificate.

8 (g) WRITTEN REASONS; JUDICIAL REVIEW.—

9 (1) DENIAL AND REVOCATION OF CERTIFI-
10 CATES.—If the Attorney General denies an applica-
11 tion for a certificate or revokes a certificate, the At-
12 torney General shall include in the notice of denial
13 or revocation a statement of the reasons relied upon
14 for the denial or revocation of such certificate.

15 (2) JUDICIAL REVIEW.—

16 (A) AFTER ADMINISTRATIVE PROCEED-
17 ING.—

18 (i) IN GENERAL.—If the Attorney
19 General denies an application submitted or
20 revokes a certificate issued under this sec-
21 tion after an opportunity for hearing on
22 the record, then any party to the health
23 care collaborative effort involved may com-
24 mence a civil action, not later than 60 days
25 after receiving notice of the denial or rev-

1 ocation, in an appropriate district court of
2 the United States for review of the record
3 of such denial or revocation.

4 (ii) CERTIFIED COPY OF RECORD.—As
5 part of the Attorney General’s answer, the
6 Attorney General shall file in such court a
7 certified copy of the record on which such
8 denial or revocation is based. The findings
9 of fact of the Attorney General may be set
10 aside only if found to be unsupported by
11 substantial evidence in such record taken
12 as a whole.

13 (B) DENIAL OR REVOCATION WITHOUT AD-
14 MINISTRATIVE PROCEEDING.—If the Attorney
15 General denies an application submitted or re-
16 vokes a certificate issued under this section
17 without an opportunity for hearing on the
18 record, then any party to the health care col-
19 laborative effort involved may commence a civil
20 action, not later than 60 days after receiving
21 notice of the denial or revocation, in an appro-
22 priate district court of the United States for de
23 novo review of such denial or revocation.

24 (h) EXEMPTION.—A person shall not be liable under
25 any of the antitrust laws for conduct necessary—

1 (1) to prepare, agree to prepare, or attempt to
2 agree to prepare an application to request a certifi-
3 cate under this section, or

4 (2) to attempt to enter into any health care col-
5 laborative effort with respect to which such a certifi-
6 cate is in effect.

7 (i) DEFINITIONS.—In this section:

8 (1) The term “antitrust laws”—

9 (A) has the meaning given such term in
10 subsection (a) of the first section of the Clayton
11 Act (15 U.S.C. 12(a)), except that such term
12 includes section 5 of the Federal Trade Com-
13 mission Act (15 U.S.C. 45) to the extent such
14 section applies to unfair methods of competi-
15 tion, and

16 (B) includes any State law similar to the
17 laws referred to in subparagraph (A).

18 (2) The term “certificate” means a certificate
19 of public advantage authorized to be issued under
20 subsection (a).

21 (3) The term “health care collaborative effort”
22 means an agreement (whether existing or proposed)
23 between 2 or more providers of health care services
24 that is entered into solely for the purpose of sharing
25 in the provision of health care services and that in-

1 volves substantial integration or financial risk-shar-
2 ing between the parties, but does not include the ex-
3 changing of information, the entering into of any
4 agreement, or the engagement in any other conduct
5 that is not reasonably required to carry out such
6 agreement.

7 (4) The term “health care services” includes
8 services related to the delivery or administration of
9 health care services.

10 (5) The term “liable” means liable for any civil
11 or criminal violation of the antitrust laws.

12 (6) The term “provider of health care services”
13 means any individual or entity that is engaged in the
14 delivery of health care services in a State and that
15 is required by State law or regulation to be licensed
16 or certified by the State to engage in the delivery of
17 such services in the State.

18 **Subtitle C—Administrative Cost** 19 **Savings**

20 **SEC. 521. ESTABLISHMENT OF STANDARDS.**

21 (a) IN GENERAL.—The Secretary shall establish,
22 after consultation with the American National Standards
23 Institute, data and transaction standards, conventions,
24 and requirements that permit the electronic interchange
25 of any health care data the Secretary determines nec-

1 essary for the efficient and effective administration of the
2 health care system.

3 (b) TIMETABLE AND COVERAGE.—The Secretary
4 shall establish standards, conventions, and requirements
5 for categories of health care data in the following order
6 and at the appropriate time (as determined by the Sec-
7 retary):

8 (1) Financial and administrative transactions,
9 including enrollment, eligibility, claims, and claims
10 status.

11 (2) Quality measurement indicators, including
12 such data necessary to satisfy the requirements
13 under section 521.

14 (3) Patient care records.

15 (c) PRIVACY AND CONFIDENTIALITY STANDARDS.—
16 In developing the standards, conventions, and require-
17 ments under subsection (a), the Secretary shall ensure the
18 protection of privacy of participants in the health care sys-
19 tem and ensure the confidentiality in the data interchange
20 system.

21 **SEC. 522. ENFORCEMENT.**

22 (a) AHPs.—An AHP may not be certified by the ap-
23 propriate regulatory authority unless such AHP complies
24 with the standards established by the Secretary under sec-
25 tion 521.

1 (b) HEALTH CARE PROVIDERS.—AHPs may only
2 contract with or employ those health care providers that
3 comply with the electronic standards established by the
4 Secretary or submit standard paper forms with the same
5 data elements to a clearinghouse which forwards the data
6 electronically to AHPs.

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